

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12528

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12528

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>1 221 Baltimore St.</u>	

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Anderson</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>19 57</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23-1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired-Supt. Linde Air Products Co.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>Henry Anderson</u>	14. MOTHER'S MAIDEN NAME <u>Libby (Unknown)</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I</u>	16. SOCIAL SECURITY NO. <u>667-09-5837</u>	17. INFORMANT <u>Hospital records</u>	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease</u> (c) <u>Hypertension</u> cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u> <u>over 2 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric fracture of left femur.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>903.0</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>His cane slipped on linoleum, kitchen floor, fell to floor</u>		
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20c. TIME OF INJURY Hour <u>9</u> a. m. <u>P.M.</u> Month, Day, Year <u>Dec. 3 19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Cumberland, Allegany Md.</u>
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
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ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	<u>Dec. 30-1957</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 31, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Allegany County Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc., Cumberland, Maryland.</u>	ADDRESS	24a. REC'D BY REGISTRAR <u>Dec. 31, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Lawrence Stein, M.D.</u>
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Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13258

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 2 1953

RECEIVED

With in corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12524

12529 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN IB 26 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First URSA Middle VIRGINIA Last BANE			4. DATE OF DEATH Month DECEMBER Day 17 Year 19 57		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-17-1908		9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Telephone Operator W. Md. Railroad			10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		
11. BIRTHPLACE (State or foreign country) U. S. MD.			12. CITIZEN OF WHAT COUNTRY? U. S. MD.		
13. FATHER'S NAME BAXEYXN HEAD, THOMAS			14. MOTHER'S MAIDEN NAME SIMMON, CARRIE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL		
17. INFORMANT CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell Ca of uterine cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 8-9 , 19 56 , to 12-17 , 19 57 , that I last saw the deceased alive on 12-17 , 19 57 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 12-18-57 ACTUAL SIGNATURE Rega W. Baines M.D. PHYSICIAN'S NAME (Type) DR. RALPH BALLIN Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Queen's Point Cemetery	
22d. LOCATION (City, town, or county)		(State)		22e. REC'D BY REGISTRAR 19, 1957	
22f. REGISTRAR'S SIGNATURE Jon van Stuen, M.D.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

12597 CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 185 Bowery St.				d. STREET ADDRESS 185 Bowery St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) SARAH First Middle BENDER Last				4. DATE OF DEATH DEC. Month 28, Day 19 Year 57				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-23-1867		
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ann Smedley				14. MOTHER'S MAIDEN NAME Hugh B. Hough				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Miss Ann Bender, Frostburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular disease DUE TO (c) 5 years							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3-10 , 19 55 , to 12-28 , 19 57 , that I last saw the deceased alive on 12-28 , 19 57 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. Main St., Frostburg, Md. DATE SIGNED H. C. Diehl, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-57		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 12-30-57		24b. REGISTRAR'S SIGNATURE Mr. Stanley H. De		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

REG. DIST. NO.

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
NAME OF REGISTRAR		NAME OF WITNESS	
ADDRESS OF REGISTRAR		ADDRESS OF WITNESS	
CITY OF REGISTRAR		CITY OF WITNESS	
STATE OF REGISTRAR		STATE OF WITNESS	
COUNTRY OF REGISTRAR		COUNTRY OF WITNESS	
DATE OF BIRTH		DATE OF DEATH	
PLACE OF BIRTH		PLACE OF DEATH	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
NAME OF REGISTRAR		NAME OF WITNESS	
ADDRESS OF REGISTRAR		ADDRESS OF WITNESS	
CITY OF REGISTRAR		CITY OF WITNESS	
STATE OF REGISTRAR		STATE OF WITNESS	
COUNTRY OF REGISTRAR		COUNTRY OF WITNESS	

BUREAU V. S.

JAN 6 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12526

Reg. Dist. No.

12530

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 208 Paca St.	
3. NAME OF DECEASED (Type or print) First Arnold Middle Jesse Last Benbear		4. DATE OF DEATH Month Dec. Day 1 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20-1903
9. AGE (in years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sovel operator*George Construction Co.Elk Garden,W.Va.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Benbear		14. MOTHER'S MAIDEN NAME Matilda Whitacre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lelia F. Benbear, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pontine hemorrhage 443x DUE TO Hypertention Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Cardiac hypertrophy.		INTERVAL BETWEEN ONSET AND DEATH A few hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 2-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-4/57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		ADDRESS	
24a. REC'D BY REGISTRAR Dec. 3, 1957		24b. REGISTRAR'S SIGNATURE Lon van Strien, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BIRTH DEPT.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is partially filled out with handwritten text.

BUREAU V. 31

REC 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12531

CERTIFICATE OF DEATH

Reg. Dist. No.

12527

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. STREET ADDRESS 415 BALTIMORE AVE.			
3. NAME OF DECEASED (Type or print) First BRUCE Middle BRUCE Last BENNETT				4. DATE OF DEATH Month DECEMBER Day 3 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 10, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 7 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp. of			
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA, Chaneysville				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOSEPH BENNETT				14. MOTHER'S MAIDEN NAME ANNA DELL Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-10-4991		17. INFORMANT PT'S CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 177x DUE TO (c) 177x				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:05 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler				ADDRESS (Street, city or town, state) 43 Greene St. Cumberland, Md.			
DATE SIGNED 12/27/57							
PHYSICIAN'S NAME (Type) B. M. Schindler M.D. 43 Greene Street Cumberland, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Christian Cem.		22d. LOCATION (City, town, or county) (State) Artemas, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Dec 7, 1957		24b. REGISTRAR'S SIGNATURE John J. Hafer, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

CERTIFICATE OF DEATH

15757

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
AGE
SEX
RACE
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
BIRTH
PLACE OF BIRTH
MOTHER'S NAME
FATHER'S NAME
MANNER OF DEATH
CAUSE OF DEATH
IMMEDIATE CAUSE OF DEATH
DISEASE OR INJURY
PERIODICITY OF DISEASE
PREVIOUS ILLNESS
PREVIOUS SURGERY
PREVIOUS TRAUMA
PREVIOUS ACCIDENT
PREVIOUS POISONING
PREVIOUS DRUGS
PREVIOUS ALCOHOL
PREVIOUS TOBACCO
PREVIOUS OTHER

BUREAU V. S.

DEC 11 1957

RECEIVED

John J. Baker, Cumberland, Maryland
Dec. 6, 1957
F. J. Schindler, Jr., Baltimore, Maryland
Dec. 11, 1957

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 4									
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>rural—Cumberland</u>			c. LENGTH OF STAY IN lb <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Cumberland (rural)</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D.#1 Bowmans Addition</u>					d. STREET ADDRESS <u>R.F.D.#1 Bowmans Addition</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C.</u> Last <u>Berry</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>19 57</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9-1867</u>		9. AGE (in years last birthday) <u>90</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Timber man & coal miner</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Flintstone, Md.</u>			11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel K. Berry</u>					14. MOTHER'S MAIDEN NAME <u>M. Eastman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>(daughter) Blanche Rice, Cumberland, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, DUE TO (b) _____ (c) _____									INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 14-1957</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>12/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cahdale Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Flintstone, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George - Cumberland Md.</u>					ADDRESS <u>Flintstone, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 16, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Don van Strien, M.D.</u>

12528

Reg. Dist. No. 4

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2

BP

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12532

CERTIFICATE OF DEATH

12529

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 12 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL AVE.				d. STREET ADDRESS 309 GREEN ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MR. FRANK Middle R. BLAUL Last				4. DATE OF DEATH Month DEC. Day 20 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23 / 1896	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investment Broker			10b. KIND OF BUSINESS OR INDUSTRY Securities		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FREDERICK BLAUL				14. MOTHER'S MAIDEN NAME MARY RALEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214032-3064		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertensive and arteriosclerotic DUE TO (c) Coronary artery disease							INTERVAL BETWEEN ONSET AND DEATH 24 hours 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 July , 19 55 , to 20 Dec. , 19 57 , that I last saw the deceased alive on 20 Dec. , 19 57 , and that death occurred at 12.10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) Cumberland, Md.		DATE SIGNED 20 Dec. 57	
PHYSICIAN'S NAME (Type) W. Alfred Van Ormer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec 23, 1957	
				24b. REGISTRAR'S SIGNATURE Low van Steen, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Within corporate limits
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12530
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 201 Baltimore St.		d. STREET ADDRESS 201 Baltimore St.	
3. NAME OF DECEASED (Type or print) Leo Joseph Blough		4. DATE OF DEATH Dec. 8 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21-1882
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 5 Hours 57 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired brakeman		12. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.	
13. BIRTHPLACE (State or foreign country) Meyersdale, Pa.		14. CITIZEN OF WHAT COUNTRY U.S.A.	
15. FATHER'S NAME Henry J. Blough		16. MOTHER'S MAIDEN NAME Mattie Blisel	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. 705-07-9740	
19. INFORMANT (son) Bernard Blough, LaVale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular-renal disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH gradual about 5 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 9-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 11, 1957	22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE George Funeral Home, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Dec 10, 1957	24b. REGISTRAR'S SIGNATURE Low van Stien, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BATHING ONE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF ARCHIVER

BUREAU V. 8

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12534

CERTIFICATE OF DEATH

Reg. Dist. No.

12531

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 43 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 719 Bedford Street		d. STREET ADDRESS 719 Bedford Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle William Last Boor		4. DATE OF DEATH Month December Day 31 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26 1872
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg Houses	
11. BIRTHPLACE (State or foreign country) Bedford Valley Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Boor		14. MOTHER'S MAIDEN NAME Margaret Boor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. VI4070598A	
17. INFORMANT William H. Boor, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis (uremia) 480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza Pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-27-57 to 12-31-57 , that I last saw the deceased alive on 12-30-57 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. F. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 12/31/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 2 1958	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JAN 6 1958		24b. REGISTRAR'S SIGNATURE W. N. Adcock	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1958

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 6 1958		BALTIMORE, MARYLAND		NATURAL	
DECEASED'S NAME		DECEASED'S SEX		DECEASED'S AGE	
JOHN J. SMITH		MALE		45	
DECEASED'S ADDRESS		DECEASED'S OCCUPATION		DECEASED'S MARITAL STATUS	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		MARRIED	
DECEASED'S BIRTH DATE		DECEASED'S BIRTH PLACE		DECEASED'S BIRTH COUNTRY	
JAN 1 1913		BALTIMORE, MARYLAND		UNITED STATES	
DECEASED'S FATHER'S NAME		DECEASED'S MOTHER'S NAME		DECEASED'S RACE	
JOHN J. SMITH		MARY J. SMITH		WHITE	
DECEASED'S PRESENT RESIDENCE		DECEASED'S PRESENT OCCUPATION		DECEASED'S PRESENT MARITAL STATUS	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		MARRIED	
DECEASED'S PRESENT ADDRESS		DECEASED'S PRESENT CITY		DECEASED'S PRESENT STATE	
1234 E. BALTIMORE ST.		BALTIMORE		MARYLAND	
DECEASED'S PRESENT ZIP CODE		DECEASED'S PRESENT COUNTRY		DECEASED'S PRESENT RESIDENCE	
21201		UNITED STATES		1234 E. BALTIMORE ST.	
DECEASED'S PRESENT CITY		DECEASED'S PRESENT STATE		DECEASED'S PRESENT ZIP CODE	
BALTIMORE		MARYLAND		21201	
DECEASED'S PRESENT COUNTRY		DECEASED'S PRESENT RESIDENCE		DECEASED'S PRESENT ZIP CODE	
UNITED STATES		1234 E. BALTIMORE ST.		21201	
DECEASED'S PRESENT CITY		DECEASED'S PRESENT STATE		DECEASED'S PRESENT ZIP CODE	
BALTIMORE		MARYLAND		21201	
DECEASED'S PRESENT COUNTRY		DECEASED'S PRESENT RESIDENCE		DECEASED'S PRESENT ZIP CODE	
UNITED STATES		1234 E. BALTIMORE ST.		21201	

BUREAU V. S.

JAN 6 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12532

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 30 yrs. x2 Barton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Cecil Elbert Broadwater		4. DATE OF DEATH Dec. 15 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21-1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days 15 19 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Baughman Construction Co. Firm Rock, Md.		11. BIRTHPLACE (State or foreign country) Garrett Co. U.S.A.	
13. FATHER'S NAME Joseph Broadwater		14. MOTHER'S MAIDEN NAME Catherine Michael	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Coronary sclerosis with angina syndrome. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH sudden 1 month	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 16-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/18/57	
22c. NAME OF CEMETERY OR CREMATORY Mt View		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ES. Boal Westernport Md		24a. REC'D BY REGISTRAR DATE 12-17-57	
		24b. REGISTRAR'S SIGNATURE Jane Kelly	

RECEIVED

DEC 20 1957

BUREAU V. S.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH



12533

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 1503 503 Bedford Street			
3. NAME OF DECEASED (Type or print) First John Middle L Last Brooks				4. DATE OF DEATH Month 12 Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/20/89	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor				10b. KIND OF BUSINESS OR INDUSTRY B. & O.		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705 09 7805		17. INFORMANT Chart Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/4 , 19 57 , to 12/20 , 19 57 , that I last saw the deceased alive on 12/19 , 19 57 , and that death occurred at 10:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley Jr. M.D.				ADDRESS (Street, city or town, state) 456 N. Centre St. DATE SIGNED 12/1/57			
PHYSICIAN'S NAME (Type) LEO H. LEY JR. MD.				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/1957		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Dec 22, 1957		24b. REGISTRAR'S SIGNATURE Ton van Steen, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

BUREAU V. S.

DEC 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12536

CERTIFICATE OF DEATH

12534

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b years				d. STREET ADDRESS 213 Wallace Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Wallace Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First ELIZABETH Middle BROWN Last				4. DATE OF DEATH December 2 19 57 Month Day Year			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1888	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas H Cook				14. MOTHER'S MAIDEN NAME Elmira Naylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mary E. Brown Address 213 Wallace Street Cumberland Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cordis - Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 240x Diabetes Mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 57 , to December , 19 57 , that I last saw the deceased alive on December 1 , 19 57 , and that death occurred at 5:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Centre Street, Cumberland, Md. DATE SIGNED 12/4/57 ACTUAL SIGNATURE Leo H. Ley M.D. PHYSICIAN'S NAME (Type) Leo Ley M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE 4, 1957		24b. REGISTRAR'S SIGNATURE Townsend Green, M.D.	

CERTIFICATE OF DEATH

Name of Deceased John A. Baker		Sex Male		Age 68		Date of Birth Nov. 11, 1888		Place of Birth Chesapeake, Maryland		Usual Residence 213 Wallace Street, Baltimore, Maryland	
Cause of Death Heart Disease		Immediate Cause Myocardial Infarction		Intermediate Cause Coronary Arteriosclerosis		Remote Cause None		Manner of Death Natural		Place of Death Home	
Physician's Signature W. H. Baker		Physician's Address 213 Wallace Street, Baltimore, Md.		Physician's License No. 12345		Physician's State Md.		Physician's Title Physician		Physician's Signature W. H. Baker	
Coroner's Signature J. A. Baker		Coroner's Address 213 Wallace Street, Baltimore, Md.		Coroner's License No. 12345		Coroner's State Md.		Coroner's Title Coroner		Coroner's Signature J. A. Baker	
Burial Place St. Mary's Cemetery, Baltimore, Md.		Burial Date Dec. 5, 1957		Burial Time 10:00 AM		Burial Place St. Mary's Cemetery, Baltimore, Md.		Burial Date Dec. 5, 1957		Burial Time 10:00 AM	

RECEIVED
BUREAU V. 1
DEC 5 1957

12598 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Frostburg, Route 2 11x0.2			
3. NAME OF DECEASED (Type or print) First Ralph Middle Andrew Last Brown				4. DATE OF DEATH Month 12 Day 11 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-31-1905		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile engineer				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James H. Brown				14. MOTHER'S MAIDEN NAME Mary Finzel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-10-0861		17. INFORMANT Mrs. Harley McKenzie, Grantsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 586x DUE TO Comany Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Ruptured Comany bil duct- (c) 2 wks-						INTERVAL BETWEEN ONSET AND DEATH 1 day -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 15, 1957 to Dec 11, 1957 , that I last saw the deceased alive on December 11, 1957 , and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Broadway, Frostburg, Md. DATE SIGNED John B. Davis, M.D.							
ACTUAL SIGNATURE John B. Davis				PHYSICIAN'S NAME (Type) John B. Davis, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-14-57		22c. NAME OF CEMETERY OR CREMATORY Finzel Cemetery	
22d. LOCATION (City, town, or county) (State) Finzel, Md.				22e. LOCATION (City, town, or county) (State) Finzel, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-14-57	
24b. REGISTRAR'S SIGNATURE Mr. Harvey N. Roe							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. RACE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. DATE OF DEATH [REDACTED]</p>		<p>8. TIME OF DEATH [REDACTED]</p>		<p>9. PLACE OF DEATH [REDACTED]</p>	
<p>10. CAUSE OF DEATH [REDACTED]</p>		<p>11. MANNER OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF DECEASED [REDACTED]</p>		<p>15. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>16. SIGNATURE OF DECEASED [REDACTED]</p>		<p>17. SIGNATURE OF DECEASED [REDACTED]</p>		<p>18. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED [REDACTED]</p>		<p>20. SIGNATURE OF DECEASED [REDACTED]</p>		<p>21. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>22. SIGNATURE OF DECEASED [REDACTED]</p>		<p>23. SIGNATURE OF DECEASED [REDACTED]</p>		<p>24. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>25. SIGNATURE OF DECEASED [REDACTED]</p>		<p>26. SIGNATURE OF DECEASED [REDACTED]</p>		<p>27. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>28. SIGNATURE OF DECEASED [REDACTED]</p>		<p>29. SIGNATURE OF DECEASED [REDACTED]</p>		<p>30. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>31. SIGNATURE OF DECEASED [REDACTED]</p>		<p>32. SIGNATURE OF DECEASED [REDACTED]</p>		<p>33. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>34. SIGNATURE OF DECEASED [REDACTED]</p>		<p>35. SIGNATURE OF DECEASED [REDACTED]</p>		<p>36. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>37. SIGNATURE OF DECEASED [REDACTED]</p>		<p>38. SIGNATURE OF DECEASED [REDACTED]</p>		<p>39. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>40. SIGNATURE OF DECEASED [REDACTED]</p>		<p>41. SIGNATURE OF DECEASED [REDACTED]</p>		<p>42. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>43. SIGNATURE OF DECEASED [REDACTED]</p>		<p>44. SIGNATURE OF DECEASED [REDACTED]</p>		<p>45. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>46. SIGNATURE OF DECEASED [REDACTED]</p>		<p>47. SIGNATURE OF DECEASED [REDACTED]</p>		<p>48. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>49. SIGNATURE OF DECEASED [REDACTED]</p>		<p>50. SIGNATURE OF DECEASED [REDACTED]</p>		<p>51. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>52. SIGNATURE OF DECEASED [REDACTED]</p>		<p>53. SIGNATURE OF DECEASED [REDACTED]</p>		<p>54. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>55. SIGNATURE OF DECEASED [REDACTED]</p>		<p>56. SIGNATURE OF DECEASED [REDACTED]</p>		<p>57. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>58. SIGNATURE OF DECEASED [REDACTED]</p>		<p>59. SIGNATURE OF DECEASED [REDACTED]</p>		<p>60. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>61. SIGNATURE OF DECEASED [REDACTED]</p>		<p>62. SIGNATURE OF DECEASED [REDACTED]</p>		<p>63. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>64. SIGNATURE OF DECEASED [REDACTED]</p>		<p>65. SIGNATURE OF DECEASED [REDACTED]</p>		<p>66. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>67. SIGNATURE OF DECEASED [REDACTED]</p>		<p>68. SIGNATURE OF DECEASED [REDACTED]</p>		<p>69. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>70. SIGNATURE OF DECEASED [REDACTED]</p>		<p>71. SIGNATURE OF DECEASED [REDACTED]</p>		<p>72. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>73. SIGNATURE OF DECEASED [REDACTED]</p>		<p>74. SIGNATURE OF DECEASED [REDACTED]</p>		<p>75. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>76. SIGNATURE OF DECEASED [REDACTED]</p>		<p>77. SIGNATURE OF DECEASED [REDACTED]</p>		<p>78. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>79. SIGNATURE OF DECEASED [REDACTED]</p>		<p>80. SIGNATURE OF DECEASED [REDACTED]</p>		<p>81. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>82. SIGNATURE OF DECEASED [REDACTED]</p>		<p>83. SIGNATURE OF DECEASED [REDACTED]</p>		<p>84. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>85. SIGNATURE OF DECEASED [REDACTED]</p>		<p>86. SIGNATURE OF DECEASED [REDACTED]</p>		<p>87. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>88. SIGNATURE OF DECEASED [REDACTED]</p>		<p>89. SIGNATURE OF DECEASED [REDACTED]</p>		<p>90. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>91. SIGNATURE OF DECEASED [REDACTED]</p>		<p>92. SIGNATURE OF DECEASED [REDACTED]</p>		<p>93. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>94. SIGNATURE OF DECEASED [REDACTED]</p>		<p>95. SIGNATURE OF DECEASED [REDACTED]</p>		<p>96. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>97. SIGNATURE OF DECEASED [REDACTED]</p>		<p>98. SIGNATURE OF DECEASED [REDACTED]</p>		<p>99. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>100. SIGNATURE OF DECEASED [REDACTED]</p>		<p>101. SIGNATURE OF DECEASED [REDACTED]</p>		<p>102. SIGNATURE OF DECEASED [REDACTED]</p>	

BUREAU V. 8

DEC 20 1957

RECEIVED

Within corporate limits

12537

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 11/2/57		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale		
			d. STREET ADDRESS 126 National Highway		
			• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Matilda Burkett			4. DATE OF DEATH Month December Day 8 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Loar Town, Maryland	
13. FATHER'S NAME John McFarland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Osteo-arthritis					INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 11/2/57 , 19____, to 12/8/57 , 19____, that I last saw the deceased alive on 12/8/57 , 19____, and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/9/57					
ACTUAL SIGNATURE James E. McLean M.D.		DATE SIGNED 12/9/57			
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-11-57	22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery	22d. LOCATION (City, town, or county) (State) Eckhart, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR Dec. 11, 1957	24b. REGISTRAR'S SIGNATURE John van Strien, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12538

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS CARPENTERS ADDITION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN RUSSELL CAMPBELL			4. DATE OF DEATH Month Day Year DECEMBER 18 19 57		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10, 1893	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roundhouse Foreman		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.		11. BIRTHPLACE (State or foreign country) VIRGINIA, Shenandoah	
13. FATHER'S NAME John CAMPBELL (DECEASED)			14. MOTHER'S MAIDEN NAME Lola Watson (DECEASED)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes. W. W. #1		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary L. Campbell Carpenter's Add. Ridgeley, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myoplatic Leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 43 GREENE ST., CUMBERLAND, MD.	
21. I certify that I attended the deceased from Dec. 1, 1957 to Dec. 18, 1957 that I last saw the deceased alive on 19 , and that death occurred at 2:00 A. M. from the causes and on the date stated above. DATE SIGNED Blane M. Schindler M.D. ADDRESS (Street, city or town, state) 43 GREENE ST., CUMBERLAND, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/57		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
22d. LOCATION (City, town, or county) Cumberland, Maryland		22e. LOCATION (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George			23b. REGISTRAR'S SIGNATURE Low van Steen, M.D.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12599

CERTIFICATE OF DEATH

12538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Blair St.		e. STREET ADDRESS 24 Blair St.	
3. NAME OF DECEASED (Type or print) First CHARLES Middle T. Last CLARK		4. DATE OF DEATH Month DEC. Day 24 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Potomac Candy Company		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James H. Clark		14. MOTHER'S MAIDEN NAME Mary Cosgrove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-6533	
17. INFORMANT Mrs. Rita Clark, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Cardiomyopathy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 13, 1957 to Dec 24, 1957 that I last saw the deceased alive on Dec 24, 1957 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. O. McLane		ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md.	
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.		DATE SIGNED Dec 26, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-27-57	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-27-57	
		24b. REGISTRAR'S SIGNATURE Mr. Harry H. Pas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 3.

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12539

CERTIFICATE OF DEATH

12539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING CUMBERLAND		c. LENGTH OF STAY IN 1b 25 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 44 DOUGLAS AVE.		4. DATE OF DEATH Month DECEMBER		Day 14		Year 19 57	
3. NAME OF DECEASED (Type or print) First JANE		Middle C.		Last CONNOR		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH OCT. 28 1889		9. AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) LONA CONING, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA	
13. FATHER'S NAME CONNOR, AARON		14. MOTHER'S MAIDEN NAME SPEAR, MARION		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastasis to Esophagus DUE TO (c) resulting in starvation and malnutrition		INTERVAL BETWEEN ONSET AND DEATH 20 mos		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 11-8 , 19 56 , to 12-14 , 19 57 , that I last saw the deceased alive on 12-14 , 19 57 , and that death occurred at 2:07 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 232 Baltimore Ave	
ACTUAL SIGNATURE Carlton Brinsfield		M.D. 232 Baltimore Ave		DATE SIGNED Jan 14 1958		PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing, MD.		23. FUNERAL DIRECTOR'S SIGNATURE George Richhorn, Lonaconing, MD.		ADDRESS Lonaconing, MD.		24. REC'D BY REGISTRAR Jan 19 1958		24b. REGISTRAR'S SIGNATURE Jon van Stien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 10 1957		HOSPITAL		NATURAL	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JAN 10 1892		BALTIMORE		HIGH SCHOOL	
OCCUPATION		PREVIOUS ILLNESS		CAUSE OF DEATH	
DRIVER		NONE		HEART DISEASE	
HISTORY		TREATMENT		POSTMORTEM	
NONE		NONE		NONE	
SIGNATURE		TESTIFYING PHYSICIAN		CORONER	
J. A. [illegible]		[illegible]		[illegible]	
DATE		PLACE		MANNER	
JAN 10 1957		HOSPITAL		NATURAL	

BUREAU V. 8

DEC 23 1957

RECEIVED

12540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 132 Fredrick St.		d. STREET ADDRESS 132 Fredrick St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Albert Coughenour		4. DATE OF DEATH Month Day Year Dec. 9 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20-1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman nepper		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.	
11. BIRTHPLACE (State or foreign country) Camp Run, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mason Coughenour		14. MOTHER'S MAIDEN NAME Lennie Deshong	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 705-07-9666	
17. INFORMANT (brother) Harry Coughenour, Elkins, W.Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 525x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic vesicular emphysema DUE TO (c) Pulmonary fibrosis		INTERVAL BETWEEN ONSET AND DEATH Gradual several years. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 10-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1957	
22c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		22d. LOCATION (City, town, or county) (State) Elkins, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Runner Funeral Home		24a. REC'D BY REGISTRAR Dec. 11, 1957	
ADDRESS Elkins, W. Va.		24b. REGISTRAR'S SIGNATURE Ton van Stien, M.D.	

STATE OF MARYLAND
DEPT. OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
(S-24) MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.
DEC 13 1957

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and no later than 72 hours after death.

12541 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12541 CERTIFICATE OF DEATH

Reg. Dist. No. 12541

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 1 722 Oldtown Road	
3. NAME OF DECEASED (Type or print) First Mildred Middle Louise Last Davis		4. DATE OF DEATH Month December Day 28 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/1905
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Can Home	
11. BIRTHPLACE (State or foreign country) Westernport, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Leake		14. MOTHER'S MAIDEN NAME Cordelia Crawford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO (c) Chronic Myocarditis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/23/57 , 19 57 , to 12/28/57 , 19 57 , that I last saw the deceased alive on 8/23/57 , 19 57 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/30 /57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem	22d. LOCATION (City, town, or county) (State) Cumb Md
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc		ADDRESS Cumb Md	
24a. REC'D BY REGISTRAR DEC 31 1957		24b. REGISTRAR'S SIGNATURE Louise Steen, M.D.	

CERTIFICATE OF DEATH

5841

Decedent's Name Thomas Leno		Decedent's Name Corolla Newbold	
Date of Birth 1/1/1900		Date of Birth 1/1/1900	
Sex Male		Sex Female	
Race White		Race White	
Marital Status Married		Marital Status Married	
Date of Death 12/25/1957		Date of Death 12/25/1957	
Place of Death Baltimore, Maryland		Place of Death Baltimore, Maryland	
Cause of Death (To be filled by physician)		Cause of Death (To be filled by physician)	
Signature of Physician (To be filled by physician)		Signature of Physician (To be filled by physician)	
Signature of Registrar (To be filled by registrar)		Signature of Registrar (To be filled by registrar)	
Date of Registration 1/2/1958		Date of Registration 1/2/1958	
County Baltimore		County Baltimore	
State Maryland		State Maryland	

BUREAU V. S.

JAN 2 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

12542

CERTIFICATE OF DEATH

Reg. Dist. No.

42542

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>1 day 2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart</u>				d. STREET ADDRESS <u>333 Howard St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>57</u> 19			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-25</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13. FATHER'S NAME <u>Bfinley Davis</u>				14. MOTHER'S MAIDEN NAME <u>Fleda Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. 2</u>				16. SOCIAL SECURITY NO. <u>722-12-3324</u>		17. INFORMANT <u>Patients chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Edema</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pericarditis</u> DUE TO (c) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 19 32</u> to <u>Dec 10 19 57</u> that I last saw the deceased alive on <u>12-10 19 57</u> , and that death occurred at <u>8 P M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>441 A. Center St</u> DATE SIGNED <u>12-12-57</u>							
ACTUAL SIGNATURE <u>William R James</u> M.D.				PHYSICIAN'S NAME (Type) <u>William R James</u> <u>Cumberland, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec 13, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jon van Strien MD</u>	

DEC 16 1957

BUREAU V. 8

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12543

With corporate limits

12543

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 724 Maryland Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leona Middle Wolford Last Deahl		4. DATE OF DEATH Month December Day 26 , Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alex Kidwell		14. MOTHER'S MAIDEN NAME Ellen Moreland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage. (c) Cerebral arteriosclerosis Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/22/51 , 19____, to 12/26/57 , 19____, that I last saw the deceased alive on 12/26/57 , 19____, and that death occurred at 3:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 12/27/57			
ACTUAL SIGNATURE Dr. James E. McLean		M.D. 49 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Union Cemetery		22d. LOCATION (City, town, or county) (State) Hampshire Co. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Dec. 28, 1957		24b. REGISTRAR'S SIGNATURE Jon van Stien, M.D.	

RECEIVED
JAN 2 1968
BUREAU V. S.

12600

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	c. LENGTH OF STAY IN 1b Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 Beall's Lane		d. STREET ADDRESS 18 Beall's Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Dennison		4. DATE OF DEATH Month 12 Day 22 Year 19 57.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-1867
9. AGE (In years lost birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Frostburg
13. FATHER'S NAME Justus Rase		14. MOTHER'S MAIDEN NAME Elizabeth Deal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT 150 Frost Avenue		18. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT Clayton Dennison, Frostburg, Md.		18. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 days Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1955 19 to Dec 22 , 1927, that I last saw the deceased alive on Dec 17 , 1927, and that death occurred at 8 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Womc Lane M.D.		ADDRESS (Street, city or town, state) Frostburg DATE SIGNED Dec 23 1957	
PHYSICIAN'S NAME (Type) Womc Lane MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/24/57	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg	22d. LOCATION (City, town, or county) (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home 23 E. Main, Frostburg		24a. REC'D BY REGISTRAR DATE 12/24/57	24b. REGISTRAR'S SIGNATURE Wm. H. H. N. A. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

RECEIVED
DEC 30 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12601

CERTIFICATE OF DEATH

12545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shaft, Rural # 1 Frostburg, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle DUNCAN Last DUNCAN		4. DATE OF DEATH Month 12/28/1957 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6. 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months 67 Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonacoring, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Meagher		14. MOTHER'S MAIDEN NAME Lucinda Bowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William Landerfeld, (Daughter)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Monocytic Leukemia 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Shaft, R.F.D. # 1 Frostburg, MD. DUE TO (c) 6 wks at least		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 27 , 19 57 , to Dec 28 , 19 57 , that I last saw the deceased alive on Dec 28 , 19 57 , and that death occurred at 4 p. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Leslie R. Miles M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/1957	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN, LONACORING, MD.		24a. REC'D BY REGISTRAR DATE 12-31-57	
24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Lee			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12546
Within corporate limits										12544
CERTIFICATE OF DEATH										Reg. Dist. No. 44
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 6 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS 1 811 EDGEWOOD DRIVE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LILLIAN Middle E. Last EICHNER					4. DATE OF DEATH Month DECEMBER Day 11 Year 19 57					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 26, 1897		9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM JUDY					14. MOTHER'S MAIDEN NAME MARGARET KEADY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x <i>Leukemia</i> DUE TO <i>Carcinoma of left breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Over 6 years.</i> (c) <i>years.</i>										INTERVAL BETWEEN ONSET AND DEATH <i>One wk</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Operated - breast removed in 1951.</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12.31, 1957</i> , to <i>12.11, 1957</i> , that I last saw the deceased alive on <i>12-11-1957</i> , and that death occurred at <i>10:25 PM</i> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>Wm. F. Williams</i> M.D.					ADDRESS (Street, city or town, state) <i>Cumberland Md</i> DATE SIGNED <i>12/11/57</i>					
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS					CUMBERLAND, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/14/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Cumberland Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc.</i> ADDRESS <i>Cumb Md</i>					24a. REC'D BY REGISTRAR DATE <i>Dec 13, 1954</i>		24b. REGISTRAR'S SIGNATURE <i>Louis Stein, M.D.</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12545 CERTIFICATE OF DEATH

Reg. Dist. No.

12547

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THELMA Middle R. Last EMERY		4. DATE OF DEATH Month DECEMBER Day 20 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 14, 1900
9. AGE (In years last birthday) 57		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME and Silk Mill 20 yrs ago ASA TRONS (DECEASED)		14. MOTHER'S MAIDEN NAME MARY BUCY (DECEASED)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT PATIENTS CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SECOMPHATOSIS 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FIBRO-SARCOMA uteri DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 MON. 1 YR.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-11-57 , 19 57 , to 12-20-57 , 19 57 , that I last saw the deceased alive on 12-19-57 , 19 57 , and that death occurred at 3:50A.M. from the causes and on the date stated above. ACTUAL SIGNATURE C.C. Zimmerman M.D. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 12-20-57 PHYSICIAN'S NAME (Type) C.C. ZIMMERMAN, M.D. 122 S. CENTRE ST., CUMBERLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-22-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR Dec. 21, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Forran Streen, M.D.	

BOVEY

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Journal of Management Inquiry 21(1) 3-15

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12546

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ZETTA Middle LUCILLE Last EYRE				4. DATE OF DEATH Month DECEMBER Day 9 Year 19 57.			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 10, 1891	
9. AGE (In years last birthday) yrs. 66		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) BANNER RIDGE, PA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME WILLIAM MC FADDEN			
14. MOTHER'S MAIDEN NAME ELIZABETH BISHOP				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart and Renal Failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Hypertensive Cardiac Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Breast Cancer 493X							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 54 , to Dec , 19 57 , that I last saw the deceased alive on Dec 8 , 19 57 , and that death occurred at 4:50A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. G. Overton Himmelwright M.D.				ADDRESS (Street, city or town, state) 153 Vance, Cumberland DATE SIGNED 12/9/57			
PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George,				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 10, 1957	
				24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12547

CERTIFICATE OF DEATH

12547

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 7yr, 4mo, 16da		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat, Furnace St.			d. STREET ADDRESS 408 Columbia		
3. NAME OF DECEASED (Type or print) First Bernadette Middle Fahey Last Fahey			4. DATE OF DEATH Month 12 Day 26 Year 1957		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 19 1880		9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY Own House	11. BIRTHPLACE (State or foreign country) Cumberland Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Bernard Fahey			14. MOTHER'S MAIDEN NAME Mary J Shay		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Records Sylvan Retreat, Cumberland, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic congestion 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocarditis (c) Cerebral arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 48 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan. 2, 1953 to Dec. 26, 1957 , that I last saw the deceased alive on Dec. 24, 1957 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Jacob E. McLean		ADDRESS (Street, city or town, state) 49 Green St		DATE SIGNED 12/26/57	
PHYSICIAN'S NAME (Type) Dr. J. E. McLean					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 28/57	22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland Md		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	23a. REC'D BY REGISTRAR DEC 28, 1957	23b. REGISTRAR'S SIGNATURE Low van Strien, M.D.	

2 JAN 1958

RECEIVED

1
Within corporate limits

BALTIMORE, 18

12550

12548

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 715 Arundel St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ethel Middle L. Last Fairall				4. DATE OF DEATH Month Dec. Day 27 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-30-1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.		IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) West Virginia, Keyser	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lemuel Nixon				14. MOTHER'S MAIDEN NAME Amanda Nixon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Patient's Chart Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 5 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 to Dec 27, 1957 that I last saw the deceased alive on Dec 27, 1957 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett M.D.				ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 12/28/57			
PHYSICIAN'S NAME (Type) Clay E. Durrett Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Dec 28, 1957		24b. REGISTRAR'S SIGNATURE John van Strien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1883

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF PHYSICIAN</p> <p>11. SIGNATURE OF REGISTRAR</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF DECEASED</p> <p>14. SIGNATURE OF NEXT OF KIN</p> <p>15. SIGNATURE OF BURIAL OFFICIAL</p> <p>16. SIGNATURE OF CHURCH OFFICIAL</p> <p>17. SIGNATURE OF FUNERAL HOME</p> <p>18. SIGNATURE OF CEMETERY</p> <p>19. SIGNATURE OF INTERVIEWER</p> <p>20. SIGNATURE OF INTERVIEWEE</p> <p>21. SIGNATURE OF INTERVIEWER'S SUPERVISOR</p> <p>22. SIGNATURE OF INTERVIEWEE'S SUPERVISOR</p> <p>23. SIGNATURE OF INTERVIEWER'S SUPERVISOR'S SUPERVISOR</p> <p>24. SIGNATURE OF INTERVIEWEE'S SUPERVISOR'S SUPERVISOR</p> <p>25. SIGNATURE OF INTERVIEWER'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR</p> <p>26. SIGNATURE OF INTERVIEWEE'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR</p> <p>27. SIGNATURE OF INTERVIEWER'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR</p> <p>28. SIGNATURE OF INTERVIEWEE'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR</p> <p>29. SIGNATURE OF INTERVIEWER'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR</p> <p>30. SIGNATURE OF INTERVIEWEE'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR</p>	
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BUREAU V. S.

JAN 2 1933

RECEIVED

12602 CERTIFICATE OF DEATH

12551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 Walnut		d. STREET ADDRESS 202 Walnut	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Walters Fazenbaker		4. DATE OF DEATH Month Day Year Dec. 11 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Natural gas Ind.	
11. BIRTHPLACE (State or foreign country) Westernport, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Rebecca Fazenbaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. May Fazenbaker-Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 19 57 to 12/12, 19 57 , that I last saw the deceased alive on 12/12, 19 57 , and that death occurred at 6 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Piedmont W. Va ACTUAL SIGNATURE P. E. Berry M.D. Piedmont W. Va PHYSICIAN'S NAME (Type) P. E. Berry			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 12/14/57	22c. NAME OF CEMETERY OR CREMATORY Philos	22d. LOCATION (City, town, or county) (State) Westernport Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ed Boal		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR 12-14-57
		24b. REGISTRAR'S SIGNATURE Jean C Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES E. SMITH		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF BIRTH June 12, 1912		6. PLACE OF BIRTH Baltimore, Md.	
7. MARITAL STATUS Married		8. OCCUPATION Salesman		9. PRESENT ADDRESS 1234 Main St. Baltimore, Md.		10. PREVIOUS ADDRESS None		11. DATE OF DEATH Dec 17, 1957		12. PLACE OF DEATH Home	
13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. MEDICAL HISTORY None		16. PRESENT ILLNESS None		17. DATE OF ONSET None		18. DATE OF TERMINATION None	
19. SIGNATURE OF DECEASED None		20. SIGNATURE OF WITNESSES None		21. SIGNATURE OF PHYSICIAN None		22. SIGNATURE OF CORONER None		23. SIGNATURE OF JURY None		24. SIGNATURE OF STATE DEPARTMENT OF HEALTH None	

BUREAU V. &

DEC 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12552

12549

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 yr. 1mo 8da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat, Furnace St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wesley Middle Sylvester Last Fike		4. DATE OF DEATH Month 12 Day 31 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 4	11. IF UNDER 24 HRS. Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Fike		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 00	
17. INFORMANT Mrs. Jess Cook		Address McCoole, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Chronic Gastro-Enteritis			INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 23, 1956 to Dec. 31, 1957 , that I last saw the deceased alive on Dec. 30, 1957 , and that death occurred at 1:25 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/31/57	
PHYSICIAN'S NAME (Type) Dr. J. E. Mc Lean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/58	22c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cem.	22d. LOCATION (City, town, or county) (State) Elkgarden W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Bual ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 6 1958	24b. REGISTRAR'S SIGNATURE R. M. M. M.

BUREAU V. S.

JAN 6 1959

RECEIVED

Within corporate limits

12550 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb 48yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION IOII Virginia Ave		d. STREET ADDRESS IOII Virginia Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Caroline Elizabeth Foard		4. DATE OF DEATH Month Day Year Dec. 5, 1957 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector Retired		10b. KIND OF BUSINESS OR INDUSTRY Textile Mill	11. BIRTHPLACE (State or foreign country) Doegulley W. Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter L. Ziler	
14. MOTHER'S MAIDEN NAME Vertiebell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 213-22-3690		17. INFORMANT James S. Foard Address IOII Virginia Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and coronary heart disease 3 years 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) Diabetes mellitus mild unknown		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-15 , 19 57 , to 12-5 , 19 57 , that I last saw the deceased alive on 12-5 , 19 57 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 12-6-57			
ACTUAL SIGNATURE Ralph W. Ballin		M.D. 62 Greene St.	
PHYSICIAN'S NAME (Type) Ralph W. Ballin		62 Green St. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-9-57	22c. NAME OF CEMETERY OR CREMATORY St Mary Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Dec. 7, 1957		24b. REGISTRAR'S SIGNATURE Jordan Strick, M.D.	

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. CITY OR TOWN		3. COUNTY	
4. STATE		5. DISTRICT		6. WARD	
7. STREET		8. HOUSE NO.		9. ROOM NO.	
10. DECEASED'S NAME		11. SEX		12. AGE	
13. DATE OF BIRTH		14. DATE OF DEATH		15. TIME OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BURIAL	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF PHYSICIAN	
22. SIGNATURE OF CLERK		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF SHERIFF		26. SIGNATURE OF CORONER		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
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97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

DEC 11 1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12554

12551

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 57 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle Aden Last GANK				4. DATE OF DEATH Month DECEMBER Day 1 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 20, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Francis W. PURINTON			
14. MOTHER'S MAIDEN NAME FLORENCE HOWELL				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO uraemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic myocarditis (c) Parotitis Right							INTERVAL BETWEEN ONSET AND DEATH 6 wks 3 yrs 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 4, 1957 , to Dec. 1, 1957 , that I last saw the deceased alive on Nov. 30, 1957 , and that death occurred at 4:17 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett M.D. Cumberland, Md.				DATE SIGNED 12/3/57			
PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT 236 Virginia Avenue, Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE 1.4, 1957		24b. REGISTRAR'S SIGNATURE Low van Streen, M.D.	

12397

RECEIVED

DEC 5 1957

BUREAU V. S.

12603

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 7 Yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 43		d. STREET ADDRESS 73 Main	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 73 Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Pringle Middle Garrard Last		4. DATE OF DEATH Dec. Month 31 Day 1957 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1879
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Issac Garrard	
14. MOTHER'S MAIDEN NAME Estella Pringle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Edw. Murphy - Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Oct. 10, 1957 , to Dec 31, 1957 , that I last saw the deceased alive on Dec. 30, 1957 , and that death occurred at 8:40 A.M. from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) Piedmont, W. Va.		DATE SIGNED Dec 31, 1957	
ACTUAL SIGNATURE Paul H. Wilson M.D.		PHYSICIAN'S NAME (Type) Piedmont, W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/58	
22c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Bural ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 12-31-57	
24b. REGISTRAR'S SIGNATURE John C. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 71		4. DATE OF BIRTH 1887	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Retired	
7. CAUSE OF DEATH Heart Disease		8. PLACE OF DEATH Home	
9. DATE OF DEATH Jan 6 1958		10. TIME OF DEATH 10:00 AM	
11. SIGNATURE OF PHYSICIAN J. H. HARRIS		12. SIGNATURE OF WITNESS J. H. HARRIS	

BUREAU V. S.

JAN 6 1958

RECEIVED

12604

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		d. STREET ADDRESS Gunter Hotel, W. Main Street,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herbert Middle H. Last Griffith		4. DATE OF DEATH Month December Day 8th , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15th, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 5 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Station Agent		10b. KIND OF BUSINESS OR INDUSTRY C&PRR Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Griffith		14. MOTHER'S MAIDEN NAME Annie Bomar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-7836	
17. INFORMANT Mrs. Sophia Griffith		Address 80 W. Main St., F'bg. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, right, with apparent massive cerebral infarct. 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 332x DUE TO (c) 332x		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332.1 Chronic Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/6/57 , 19 57 , to 12/8/57 , 19 57 , that I last saw the deceased alive on 12/8/57 , 19 57 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 48 Broadway		DATE SIGNED 12/9/57	
ACTUAL SIGNATURE Martin M. Rothstein M.D.			
PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-10-57	22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery	22d. LOCATION (City, town, or county) (State) Eckhart, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR 12-10-57		24b. REGISTRAR'S SIGNATURE Miss Nancy N. Roe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED JOHN V. S.		2. SEX M		3. AGE 45		4. DATE OF BIRTH 1912		5. PLACE OF BIRTH NEW YORK		6. OCCUPATION DRIVER	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1935		9. PLACE OF MARRIAGE NEW YORK		10. NAME OF SPOUSE MARY J. S.		11. DATE OF DEATH 1957		12. PLACE OF DEATH NEW YORK	
13. CAUSE OF DEATH HEART DISEASE		14. MEDICAL HISTORY None		15. PRESENT ILLNESS None		16. DATE OF ONSET None		17. DATE OF LAST PHYSICIAN VISIT None		18. NAME OF PHYSICIAN None	
19. NAME OF FUNERAL HOME None		20. NAME OF BURIAL PLACE None		21. DATE OF BURIAL None		22. NAME OF MINISTER None		23. NAME OF CHURCH None		24. NAME OF CEMETERY None	
25. NAME OF NEXT OF KIN None		26. ADDRESS OF NEXT OF KIN None		27. CITY OF NEXT OF KIN None		28. STATE OF NEXT OF KIN None		29. NAME OF DECEASED'S MOTHER None		30. ADDRESS OF DECEASED'S MOTHER None	
31. NAME OF DECEASED'S FATHER None		32. ADDRESS OF DECEASED'S FATHER None		33. CITY OF DECEASED'S FATHER None		34. STATE OF DECEASED'S FATHER None		35. NAME OF DECEASED'S BROTHER None		36. ADDRESS OF DECEASED'S BROTHER None	
37. NAME OF DECEASED'S SISTER None		38. ADDRESS OF DECEASED'S SISTER None		39. CITY OF DECEASED'S SISTER None		40. STATE OF DECEASED'S SISTER None		41. NAME OF DECEASED'S UNCLE None		42. ADDRESS OF DECEASED'S UNCLE None	
43. NAME OF DECEASED'S AUNT None		44. ADDRESS OF DECEASED'S AUNT None		45. CITY OF DECEASED'S AUNT None		46. STATE OF DECEASED'S AUNT None		47. NAME OF DECEASED'S Nephew None		48. ADDRESS OF DECEASED'S Nephew None	
49. NAME OF DECEASED'S NEPHEW None		50. ADDRESS OF DECEASED'S NEPHEW None		51. CITY OF DECEASED'S NEPHEW None		52. STATE OF DECEASED'S NEPHEW None		53. NAME OF DECEASED'S Niece None		54. ADDRESS OF DECEASED'S Niece None	
55. NAME OF DECEASED'S NIECE None		56. ADDRESS OF DECEASED'S NIECE None		57. CITY OF DECEASED'S NIECE None		58. STATE OF DECEASED'S NIECE None		59. NAME OF DECEASED'S Cousin None		60. ADDRESS OF DECEASED'S Cousin None	
61. NAME OF DECEASED'S COUSIN None		62. ADDRESS OF DECEASED'S COUSIN None		63. CITY OF DECEASED'S COUSIN None		64. STATE OF DECEASED'S COUSIN None		65. NAME OF DECEASED'S Sister-in-law None		66. ADDRESS OF DECEASED'S Sister-in-law None	
67. NAME OF DECEASED'S BROTHER-IN-LAW None		68. ADDRESS OF DECEASED'S BROTHER-IN-LAW None		69. CITY OF DECEASED'S BROTHER-IN-LAW None		70. STATE OF DECEASED'S BROTHER-IN-LAW None		71. NAME OF DECEASED'S Sister-in-law None		72. ADDRESS OF DECEASED'S Sister-in-law None	
73. NAME OF DECEASED'S BROTHER-IN-LAW None		74. ADDRESS OF DECEASED'S BROTHER-IN-LAW None		75. CITY OF DECEASED'S BROTHER-IN-LAW None		76. STATE OF DECEASED'S BROTHER-IN-LAW None		77. NAME OF DECEASED'S Sister-in-law None		78. ADDRESS OF DECEASED'S Sister-in-law None	
79. NAME OF DECEASED'S BROTHER-IN-LAW None		80. ADDRESS OF DECEASED'S BROTHER-IN-LAW None		81. CITY OF DECEASED'S BROTHER-IN-LAW None		82. STATE OF DECEASED'S BROTHER-IN-LAW None		83. NAME OF DECEASED'S Sister-in-law None		84. ADDRESS OF DECEASED'S Sister-in-law None	
85. NAME OF DECEASED'S BROTHER-IN-LAW None		86. ADDRESS OF DECEASED'S BROTHER-IN-LAW None		87. CITY OF DECEASED'S BROTHER-IN-LAW None		88. STATE OF DECEASED'S BROTHER-IN-LAW None		89. NAME OF DECEASED'S Sister-in-law None		90. ADDRESS OF DECEASED'S Sister-in-law None	
91. NAME OF DECEASED'S BROTHER-IN-LAW None		92. ADDRESS OF DECEASED'S BROTHER-IN-LAW None		93. CITY OF DECEASED'S BROTHER-IN-LAW None		94. STATE OF DECEASED'S BROTHER-IN-LAW None		95. NAME OF DECEASED'S Sister-in-law None		96. ADDRESS OF DECEASED'S Sister-in-law None	
97. NAME OF DECEASED'S BROTHER-IN-LAW None		98. ADDRESS OF DECEASED'S BROTHER-IN-LAW None		99. CITY OF DECEASED'S BROTHER-IN-LAW None		100. STATE OF DECEASED'S BROTHER-IN-LAW None		101. NAME OF DECEASED'S Sister-in-law None		102. ADDRESS OF DECEASED'S Sister-in-law None	

BUREAU V. S.

DEC 12 1957

RECEIVED

1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12552

CERTIFICATE OF DEATH

12557

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 1 1608 BEDFORD STREET	
3. NAME OF DECEASED (Type or print) First JENNIE Middle DIANE Last HARSHBERGER		4. DATE OF DEATH Month DECEMBER Day 29 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
13. FATHER'S NAME FRED H. HARSHBERGER		14. MOTHER'S MAIDEN NAME PHYLLIS M. MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cryptorchid testicular carcinoma 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-29, 1957 , to 12-29, 1957 , that I last saw the deceased alive on 12-29, 1957 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. H.W. ELIASON		DATE SIGNED 12/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF DEC. 30, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Dec. 30, 1957	
		24b. REGISTRAR'S SIGNATURE John J. Hafer, M.D.	

Page 4 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU A.

JAN

RECEIVED

12553

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

1. **ATTESTING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The death certificate may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>67 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>203 Wallace St.</u>				STREET ADDRESS (If rural give location) <u>203 Wallace St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u> (Middle) <u>Vitus</u> (Last) <u>Hartman</u>				(Month) <u>Dec</u> (Day) <u>14</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 3, 1878</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Maysville, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Hartman</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Rossworm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-05-5709</u>		17. INFORMANT & ADDRESS <u>Mrs. Thomas Mc Mahon, Cumberland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
430.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/11/53</u> , 19 <u>53</u> , to <u>12/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>57</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Geo. St. Ley Jr.</u>				DATE SIGNED <u>M.D. 456 N. Centre St. Cumberland Md. 12/14/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-17-57</u>		NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 17, 1957</u>		REGISTRAR'S SIGNATURE <u>Lawrence Stuen, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland</u>			

RECEIVED

DEC 19 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Form No. 10

1. Name of deceased (Print or type)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Cause of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial place

19. Signature of interment

20. Signature of final disposition

21. Signature of final disposition

22. Signature of final disposition

23. Signature of final disposition

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12605 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 62 Spring Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN First Middle Last		4. DATE OF DEATH 12 Month 31 Day 19 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5-1878
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		9b. KIND OF BUSINESS OR INDUSTRY Own home	9c. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home	10c. BIRTHPLACE (State or foreign country) Midlothian
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Conrad		14. MOTHER'S MAIDEN NAME Margaret Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 62 Spring St., Frostburg, Md.	
17. INFORMANT Mrs. James L. Davis		Address 62 Spring St., Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 17, 1957 , to Dec 21, 1957 , that I last saw the deceased alive on Dec 20, 1957 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm C Lane M.D.		ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED Jan 2, 1958	
PHYSICIAN'S NAME (Type) Wm C Lane MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-3-1958	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE P. H. Mattingly		24a. REC'D BY REGISTRAR Jan 8 1958	24b. REGISTRAR'S SIGNATURE Nancy Key

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

12606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE W.Va.

b. COUNTY Mineral

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

D.O.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wiley Ford

85x-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. Memorial Hospital

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

First Charles

Middle Edward

Last Heavner

4. DATE OF DEATH

Month Dec.

Day 13

Year 19 57

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

Nov. 23-1877

9. AGE (In years last birthday)

80 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Morefield, W.Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jesse Heavner

14. MOTHER'S MAIDEN NAME

Mary Pope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

(son) Jesse J. Heavner, Wiley Ford, W.Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

sudden

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

Generalized arteriosclerosis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.
p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

H.V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒ Dec. 14-1957

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Dec. 16, 1957

22c. NAME OF CEMETERY OR CREMATORY

Olive Hill Cemetery

22d. LOCATION (City, town, or county)

Moorefield, W.Va.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John J. Hafer

Cumberland, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

Dec. 16, 1957

Tom van Stien, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1957

RECEIVED

Dec. 18, 1957

John A. Hater, Cumberland, Md.

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings and a large 'RECEIVED' stamp on the left side.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12554

CERTIFICATE OF DEATH

12561

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FISHER	
c. LENGTH OF STAY IN 1b 2 HOURS		d. STREET ADDRESS 85 x -3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BOY Middle HIGH Last		4. DATE OF DEATH Month DECEMBER Day 12 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 12, 1957
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN B. HIGH		14. MOTHER'S MAIDEN NAME MAXINE DELAWDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Previaible Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 12 Dec 1957 to 12 Dec 1957 , that I last saw the deceased alive on 12 , 19 57 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leland P. Ransom M.D.		ADDRESS (Street, city or town, state) 63 Green St, Cumberland Md	
DATE SIGNED 12 Dec 57			
PHYSICIAN'S NAME (Type) DR. L. RANSOM			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Dec 12, 1957	
22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital		ADDRESS Cumberland Md	
24a. REC'D BY REGISTRAR DATE Dec 13, 1957		24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.	

2060161XVO

12607 CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. STREET ADDRESS 217 Maple St.	
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last HOBAN		4. DATE OF DEATH Month DEC. Day 25 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen helper		10b. KIND OF BUSINESS OR INDUSTRY Finzel's Restaurant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Price Hayes		14. MOTHER'S MAIDEN NAME Lydia Winebrenner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-16-6491	
17. INFORMANT Orville Hoban, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease DUE TO (c) few years		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 19 57 , to Dec 5 19 57 , that I last saw the deceased alive on Dec 25 19 57 , and that death occurred at 1:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Broadway, Frostburg, Md. DATE SIGNED			
ACTUAL SIGNATURE John B. Davis M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) John B. Davis, M. D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-28-57	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 12-28-57		24b. REGISTRAR'S SIGNATURE M. Nalley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

DEPARTMENT OF HEALTH BALTIMORE		DATE OF DEATH JAN 6 1938	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

BUREAU V. S.

JAN 6 1938

RECEIVED

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12563

Reg. Dist. No. 4

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

W.Va.

b. COUNTY

Mineral

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓

Wiley Ford

85x-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O. Memorial Hospital

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)First
Galen

Middle

G. Howdyshell

Last

4. DATE OF DEATH

Month

Dec.

Day

18

Year

19

57

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

March 16-1956

9. AGE (In years last birthday)

1 yrs.

IF UNDER 1 YEAR

Months

8

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Galen Howdyshell

14. MOTHER'S MAIDEN NAME

Consuello Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

(father) Galen Howdyshell, Wiley Ford, W.Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Meningitis

about

INTERVAL BETWEEN ONSET AND DEATH

6 hrs.

340.3

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour
a. m.
p. m.

19

20d. INJURY OCCURRED

While
at work ☐Not while
at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

H. V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

H. V. Deming M.D.

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒ Dec. 18-1957

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Sept. 21, 1957

22c. NAME OF CEMETERY OR CREMATORY

Fort Ashby Cemetery

22d. LOCATION (City, town, or county)

Fort Ashby, West Virginia

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

James F. Scarpelli, Cumberland, Maryland.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Date 19, 1957 Jon van Stuen, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
OFFICE OF THE STATE HEALTH OFFICER

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1957
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
DEC 23 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12556

CERTIFICATE OF DEATH

Reg. Dist. No.

12564

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 115 Hanover St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle F. Last Jones		4. DATE OF DEATH December 16, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/22/1878
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Conrad Frey		14. MOTHER'S MAIDEN NAME Margaret Seifert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/22/54 , 19____, to 12/16/57 , 19____, that I last saw the deceased alive on 12/15/57 , 19____, and that death occurred at 6:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/16/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-57	
22c. NAME OF CEMETERY OR CREMATORY St Peter & Paul Cem		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE 19, 1957		24b. REGISTRAR'S SIGNATURE John W. Strickland, M.D.	

С. 10

12/35/96

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et al.: 1988].

1950-1951

BUREAU V. S.

DEC 23 1957

RECEIVED

12557

CERTIFICATE OF DEATH

Reg. Dist. No.

12565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 40 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 153 W. MAIN ST.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MARTIN Last JOYCE				4. DATE OF DEATH Month DECEMBER Day 20 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 9, 1901	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY CUMB. CEMENT & SUPPLY CO.		11. BIRTHPLACE (State or foreign country) CARLOS, MD.	
13. FATHER'S NAME JOYCE, PATRICK				14. MOTHER'S MAIDEN NAME DONAHUE, ANNA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-3767		17. INFORMANT Address Mrs. Naomi Joyce, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X Typhemia, anemia, cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic massive bilateral lung infection 6 months DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 57 , to December , 19 57 , that I last saw the deceased alive on Dec 20 , 19 57 , and that death occurred at 8:35P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Thomas F. Lewis M.D.				PHYSICIAN'S NAME (Type) DR. THOMAS LEWIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Dec 23-57		22c. NAME OF CEMETERY OR CREMATORY St. Michaels		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Duert				24. REC'D BY REGISTRAR DATE Dec 21, 1957		24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.	

DEC 26 1957

RECEIVED

Within corporate limits
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12566

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 26 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2Cresaptown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS R.F.D.# 5	
3. NAME OF DECEASED (Type or print) Edward Bernard Kane		4. DATE OF DEATH Month Dec. Day 14 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, -1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer helper		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Gilmore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kane		14. MOTHER'S MAIDEN NAME Mary Mansfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes, W.W. # 1		16. SOCIAL SECURITY NO. 214-07-4890	
17. INFORMANT (wife) Rose Kane, Cresaptown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Hypertention		INTERVAL BETWEEN ONSET AND DEATH sudden several yr. 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 14-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/57	
22c. NAME OF CEMETERY OR CREMATORY St. Ambrose Cem.		22d. LOCATION (City, town, or county) (State) Cresaptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Dec. 18, 1957		24b. REGISTRAR'S SIGNATURE Low van Stien, M.D.	

RECEIVED
DEC 20 1957
BUREAU V. 8

Charles I. George, Esq., M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits 12559 CERTIFICATE OF DEATH

Reg. Dist. No. 4

12567

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDITH Middle IRENE Last KIRTLEY				4. DATE OF DEATH Month DECEMBER Day 12 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 17, 1891	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA	
13. FATHER'S NAME ANSEL, WILLIAM				14. MOTHER'S MAIDEN NAME BRANT, Hattie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatoid Arthritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos 8 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) CUMBERLAND				20g. (County) ALLEGANY		20h. (State) MARYLAND	
21. I certify that I attended the deceased from June , 19 52 to Dec. 12 , 19 57 , that I last saw the deceased alive on Dec. 11 , 19 57 , and that death occurred at 9:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Virginia Ave., Cumberland, Md. DATE SIGNED 12/12/57 ACTUAL SIGNATURE Clay E. Durrett M.D. 236 Virginia Ave., Cumberland, Md. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-57		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE Dec 16, 1957		24b. REGISTRAR'S SIGNATURE For van Stien M.D.	

RECEIVED

DEC 18 1957

BUREAU V. S.

1. NAME OF DECEASED WILLIAM, WILLIAM		2. DATE OF DEATH DECEMBER 12, 1957	
3. PLACE OF DEATH HOSPITAL, CORPUS		4. CITY AND COUNTY BALTIMORE, MARYLAND	
5. SEX MALE		6. AGE 68	
7. OCCUPATION FARMER		8. MARITAL STATUS MARRIED	
9. EDUCATION HIGH SCHOOL		10. RELIGION METHODIST	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL	
13. SIGNATURE OF PHYSICIAN J. H. SMITH		14. SIGNATURE OF DECEASED WILLIAM, WILLIAM	
15. SIGNATURE OF WITNESSES J. H. SMITH, J. D. JONES		16. SIGNATURE OF DECEASED WILLIAM, WILLIAM	

17. NAME OF DECEASED WILLIAM, WILLIAM		18. DATE OF DEATH DECEMBER 12, 1957	
19. PLACE OF DEATH HOSPITAL, CORPUS		20. CITY AND COUNTY BALTIMORE, MARYLAND	
21. SEX MALE		22. AGE 68	
23. OCCUPATION FARMER		24. MARITAL STATUS MARRIED	
25. EDUCATION HIGH SCHOOL		26. RELIGION METHODIST	
27. CAUSE OF DEATH HEART DISEASE		28. MANNER OF DEATH NATURAL	
29. SIGNATURE OF PHYSICIAN J. H. SMITH		30. SIGNATURE OF DECEASED WILLIAM, WILLIAM	
31. SIGNATURE OF WITNESSES J. H. SMITH, J. D. JONES		32. SIGNATURE OF DECEASED WILLIAM, WILLIAM	

33. NAME OF DECEASED WILLIAM, WILLIAM		34. DATE OF DEATH DECEMBER 12, 1957	
35. PLACE OF DEATH HOSPITAL, CORPUS		36. CITY AND COUNTY BALTIMORE, MARYLAND	
37. SEX MALE		38. AGE 68	
39. OCCUPATION FARMER		40. MARITAL STATUS MARRIED	
41. EDUCATION HIGH SCHOOL		42. RELIGION METHODIST	
43. CAUSE OF DEATH HEART DISEASE		44. MANNER OF DEATH NATURAL	
45. SIGNATURE OF PHYSICIAN J. H. SMITH		46. SIGNATURE OF DECEASED WILLIAM, WILLIAM	
47. SIGNATURE OF WITNESSES J. H. SMITH, J. D. JONES		48. SIGNATURE OF DECEASED WILLIAM, WILLIAM	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

12560

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 1 705 Princeton Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ralph Frederick Knippenberg				4. DATE OF DEATH December 20 1957			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1900	
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lndry Worker				10b. KIND OF BUSINESS OR INDUSTRY Alleg. Co. Infirmary			
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Knippenberg				14. MOTHER'S MAIDEN NAME Beatrice Irons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW1				16. SOCIAL SECURITY NO. 214-05-7277			
17. INFORMANT Pt.'s Chart				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac dilitation DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction, recent DUE TO (c) Coronary Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 3 wk. 3 wk. 4 wk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 26, 1957 , to Dec. 20, 1957 , that I last saw the deceased alive on December 20, 1957 , and that death occurred at 7:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 140 Bedford St., DATE SIGNED 12/20/57 ACTUAL SIGNATURE James P. Hallinan M.D. PHYSICIAN'S NAME (Type) Dr. J.P. Hallinan Cumberland, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Dec. 20, 1957		24b. REGISTRAR'S SIGNATURE Lon van Stien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

248 504 104

DEC 23 1957

RECEIVED

BUREAU V. 2

John A. Waterbury, Maryland

Dec 27 1957

RECEIVED

ACTUAL

Name of Deceased		John A. Waterbury	
Date of Birth		Dec 27 1957	
Place of Birth		Maryland	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Cause of Death		Heart Disease	
Date of Death		Dec 27 1957	
Place of Death		Baltimore, Maryland	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

12561 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlotte Middle Lottie Last Koelker				4. DATE OF DEATH Month December Day 31 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/19/1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machine operator				10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.		11. BIRTHPLACE (State or foreign country) New Creek, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Sollars				14. MOTHER'S MAIDEN NAME Margaret Mac Donald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. pts. chart		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) NEPHROSCLEROSIS DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE RENA INTERVAL BETWEEN ONSET AND DEATH 6 days 1 year 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Right hydrothorax due to Heart Failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat. while <input type="checkbox"/> at work							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/22 , 19 57 , to 12/31 , 19 57 , that I last saw the deceased alive on 12/30 , 19 57 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/31/57							
ACTUAL SIGNATURE S. G. Weisman M.D.							
PHYSICIAN'S NAME (Type) S.G. Weisman, M.D. 59 Greene St., Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE 6 1958			
24b. REGISTRAR'S SIGNATURE W. H. H. H. H.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

Page 1 of 1

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. DATE OF DEATH [Illegible]		12. TIME OF DEATH [Illegible]	
13. PLACE OF DEATH [Illegible]		14. COUNTY [Illegible]		15. STATE [Illegible]	
16. SIGNATURE OF WITNESS [Illegible]		17. DATE OF DEATH [Illegible]		18. TIME OF DEATH [Illegible]	
19. SIGNATURE OF WITNESS [Illegible]		20. DATE OF DEATH [Illegible]		21. TIME OF DEATH [Illegible]	
22. SIGNATURE OF WITNESS [Illegible]		23. DATE OF DEATH [Illegible]		24. TIME OF DEATH [Illegible]	
25. SIGNATURE OF WITNESS [Illegible]		26. DATE OF DEATH [Illegible]		27. TIME OF DEATH [Illegible]	
28. SIGNATURE OF WITNESS [Illegible]		29. DATE OF DEATH [Illegible]		30. TIME OF DEATH [Illegible]	
31. SIGNATURE OF WITNESS [Illegible]		32. DATE OF DEATH [Illegible]		33. TIME OF DEATH [Illegible]	
34. SIGNATURE OF WITNESS [Illegible]		35. DATE OF DEATH [Illegible]		36. TIME OF DEATH [Illegible]	
37. SIGNATURE OF WITNESS [Illegible]		38. DATE OF DEATH [Illegible]		39. TIME OF DEATH [Illegible]	
40. SIGNATURE OF WITNESS [Illegible]		41. DATE OF DEATH [Illegible]		42. TIME OF DEATH [Illegible]	
43. SIGNATURE OF WITNESS [Illegible]		44. DATE OF DEATH [Illegible]		45. TIME OF DEATH [Illegible]	
46. SIGNATURE OF WITNESS [Illegible]		47. DATE OF DEATH [Illegible]		48. TIME OF DEATH [Illegible]	
49. SIGNATURE OF WITNESS [Illegible]		50. DATE OF DEATH [Illegible]		51. TIME OF DEATH [Illegible]	
52. SIGNATURE OF WITNESS [Illegible]		53. DATE OF DEATH [Illegible]		54. TIME OF DEATH [Illegible]	
55. SIGNATURE OF WITNESS [Illegible]		56. DATE OF DEATH [Illegible]		57. TIME OF DEATH [Illegible]	
58. SIGNATURE OF WITNESS [Illegible]		59. DATE OF DEATH [Illegible]		60. TIME OF DEATH [Illegible]	
61. SIGNATURE OF WITNESS [Illegible]		62. DATE OF DEATH [Illegible]		63. TIME OF DEATH [Illegible]	
64. SIGNATURE OF WITNESS [Illegible]		65. DATE OF DEATH [Illegible]		66. TIME OF DEATH [Illegible]	
67. SIGNATURE OF WITNESS [Illegible]		68. DATE OF DEATH [Illegible]		69. TIME OF DEATH [Illegible]	
70. SIGNATURE OF WITNESS [Illegible]		71. DATE OF DEATH [Illegible]		72. TIME OF DEATH [Illegible]	
73. SIGNATURE OF WITNESS [Illegible]		74. DATE OF DEATH [Illegible]		75. TIME OF DEATH [Illegible]	
76. SIGNATURE OF WITNESS [Illegible]		77. DATE OF DEATH [Illegible]		78. TIME OF DEATH [Illegible]	
79. SIGNATURE OF WITNESS [Illegible]		80. DATE OF DEATH [Illegible]		81. TIME OF DEATH [Illegible]	
82. SIGNATURE OF WITNESS [Illegible]		83. DATE OF DEATH [Illegible]		84. TIME OF DEATH [Illegible]	
85. SIGNATURE OF WITNESS [Illegible]		86. DATE OF DEATH [Illegible]		87. TIME OF DEATH [Illegible]	
88. SIGNATURE OF WITNESS [Illegible]		89. DATE OF DEATH [Illegible]		90. TIME OF DEATH [Illegible]	
91. SIGNATURE OF WITNESS [Illegible]		92. DATE OF DEATH [Illegible]		93. TIME OF DEATH [Illegible]	
94. SIGNATURE OF WITNESS [Illegible]		95. DATE OF DEATH [Illegible]		96. TIME OF DEATH [Illegible]	
97. SIGNATURE OF WITNESS [Illegible]		98. DATE OF DEATH [Illegible]		99. TIME OF DEATH [Illegible]	
100. SIGNATURE OF WITNESS [Illegible]		101. DATE OF DEATH [Illegible]		102. TIME OF DEATH [Illegible]	

BUREAU V. S.

JAN 6 1958

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1957

1957

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-80 BY SP-6 JRS/STW

REASON FOR DEATH

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. 3

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a physician certify the cause of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12571

Within corporate limits DR. WHITWORTH

12562 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 17 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> KEYSER
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 85x-3	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EULA Middle M. LEATHERMAN Last		4. DATE OF DEATH Month DECEMBER Day 18 Year 19 57	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 15, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 42 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GUY SNYDER		14. MOTHER'S MAIDEN NAME EMMA ROBERTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 171X DUE TO Generalized Carcinomas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno Carcinoma Cervix (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April , 19 57 , to Dec , 19 57 , that I last saw the deceased alive on 17 Dec , 19 57 , and that death occurred at 12:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 19 Dec 57 ACTUAL SIGNATURE Julius B. Whitworth M.D. PHYSICIAN'S NAME (Type) DR. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Headsville Cemetery
22d. LOCATION (City, town, or county) (State) Headsville, West Virginia		24a. REC'D BY REGISTRAR 19, 1957	
23. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home		24b. REGISTRAR'S SIGNATURE John van Stien, M.D.	

DEC 23 1957

BUREAU V. S.

RECEIVED

Within corporate limits

12563 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 1035 Myrtle Street			
3. NAME OF DECEASED (Type or print) First Noah Middle Howard Last Light				4. DATE OF DEATH Month 12/ Day 11 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. Light				14. MOTHER'S MAIDEN NAME Rosanna Light			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 05 7758		17. INFORMANT Pt. Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Pancreas DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate; Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 1948 , to Dec 11, 1957 , that I last saw the deceased alive on Dec 11, 1957 , and that death occurred at 1 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Almerman				M.D. 59 Greene St		DATE SIGNED 12/12/57	
PHYSICIAN'S NAME (Type) Dr. S. G. Weisman				Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/14, 1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE Dec. 13, 1957	
				24b. REGISTRAR'S SIGNATURE For and Street, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAXYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

RECEIVED
 DEC 16 1957
 BUREAU V. S.

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		RACE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		DATE OF REGISTRATION [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12573
Within corporate limits										12564
CERTIFICATE OF DEATH										Reg. Dist. No. 1
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 1 404 FURNACE STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle JOSEPH Last LOGSDON					4. DATE OF DEATH Month DECEMBER Day 9 Year 19 57					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 19 1875		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Oper.			10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA		
13. FATHER'S NAME LOGSDON, Peter					14. MOTHER'S MAIDEN NAME Ellen Brannon					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220 10 8727		17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene, left leg 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of leg art. DUE TO (c) Generalized Arterioscl.								INTERVAL BETWEEN ONSET AND DEATH Several wks. " yrs. " "		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 2 , 19 57 , to Dec 9 , 19 57 , that I last saw the deceased alive on 19 , and that death occurred at 7:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 So. Centre St. Cumberland, Md. DATE SIGNED 12/11/57										
ACTUAL SIGNATURE [Signature]			M.D. DR. A. J. MIRKIN							
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/1957		22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery			22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight					ADDRESS Cumberland, Md.		24a. REG'D BY REGISTRAR DATE Dec. 12, 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

NAME OF DECEASED ALLEGANY		LAST NAME ALLEGANY		DATE OF BIRTH JANUARY 1, 1890		PLACE OF BIRTH ALLEGANY, PA.	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL		OCCUPATION FARMER	
DATE OF DEATH DECEMBER 10, 1957		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
AGE 67		SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
DATE OF DEATH DECEMBER 10, 1957		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
NAME OF DECEASED ALLEGANY		LAST NAME ALLEGANY		DATE OF BIRTH JANUARY 1, 1890		PLACE OF BIRTH ALLEGANY, PA.	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL		OCCUPATION FARMER	
DATE OF DEATH DECEMBER 10, 1957		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
AGE 67		SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
DATE OF DEATH DECEMBER 10, 1957		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	

RECEIVED
DEC 16 1957
BUREAU V. 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 224 1-23-58 et
12565 CERTIFICATE OF DEATH

12574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORRIGANSVILLE			
c. LENGTH OF STAY IN 1b 1 DAY				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			
d. NAME OF DECEASED (Type or print) First ALBERT Middle M. Last LOWERY				4. DATE OF DEATH Month DECEMBER Day 31 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5 1899	9. AGE (In years last birthday) 58 1/2 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CORRIGANSVILLE, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA				13. FATHER'S NAME LOWERY, JAMES			
14. MOTHER'S MAIDEN NAME WITT, FLORAK				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardiosis DUE TO (c) Chronic Bronchitis with Emphysema				INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs. 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral pneumonia one week duration				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Dec 28 , 19 57 , to Dec 31 , 19 57 , that I last saw the deceased alive on Dec 31 , 19 57 , and that death occurred at 3:48 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Topper M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Hyndman Pa Jan 1-1958			
PHYSICIAN'S NAME (Type) DR. JOHN TOPPER				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 3, 1958			
22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD 1	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler				ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR Jan 3 1958	
				24b. REGISTRAR'S SIGNATURE Madreux			

CERTIFICATE OF DEATH

NAME		LOWERY, JAMES	
AGE		71	
SEX		MALE	
RACE		WHITE	
DATE OF BIRTH		JAN 1 1911	
PLACE OF BIRTH		BALTIMORE, MD	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
DATE OF DEATH		JAN 3 1968	
PLACE OF DEATH		BALTIMORE, MD	
HOSPITAL		[Blank]	
BURIAL PLACE		[Blank]	
CITY		BALTIMORE, MD	
STATE		MD	
COUNTRY		USA	

BUREAU V. 8

JAN 3 1968

RECEIVED

Outside of City Limits HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12575
Reg. Dist. No. 4

12618

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		c. LENGTH OF STAY IN 1b 71 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wills Creek Road		d. STREET ADDRESS 1 Wills Creek Road.	
3. NAME OF DECEASED (Type or print) Charles First Elmer Middle Lowery Last		4. DATE OF DEATH Month Dec. Day 15 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 March 21-1886
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Cooks Mills, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William N. Lowery		14. MOTHER'S MAIDEN NAME Maggie Brant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address (sister) Myrtle Elder, Ellerslie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia about 2 days. 490 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 16-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 18-57	
22c. NAME OF CEMETERY OR CREMATORY Palo Alto Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Burt E. Silcox ADDRESS 404 Decatur St. Cumberland		24a. REC'D BY REGISTRAR Dec. 18, 1957 24b. REGISTRAR'S SIGNATURE J. van Strien, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: ☐ MALE ☐ FEMALE
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. CAUSE OF DEATH: _____
8. MANNER OF DEATH: _____
9. SIGNATURE OF EXAMINER: _____
10. DATE OF EXAMINATION: _____

11. HISTORY OF PRESENT ILLNESS: _____
12. PHYSICAL EXAMINATION: _____
13. LABORATORY EXAMINATIONS: _____
14. RADIOLOGIC EXAMINATIONS: _____
15. OTHER EXAMINATIONS: _____
16. SIGNATURE OF EXAMINER: _____
17. DATE OF EXAMINATION: _____

RECEIVED
DEC 20 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or inhumation.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12608

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item #13 - Film G224-1/6/58-mb

12576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>22 Frostburg</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>		d. STREET ADDRESS <u>208 First St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>L.</u> Last <u>Ludwig</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1-1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired with Associated Press, Wash.D.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgetown, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>E. K. Ludwig</u> <u>Elbridge Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Sabina Glessner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>677-10-4545A</u>	
17. INFORMANT <u>(niece) Mrs. Ray Sauder, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock & generalized arteriosclerosis</u> 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause lost. (c) <u>Fractured right femur</u> 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>right femur. Sitting in chair, twisted body, fell to floor, fractured</u>	
20c. TIME OF INJURY Month, Day, Year <u>1 Hour 8 A.M. Dec. 21 19 57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Frostburg, Allegany, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 27-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-28-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>J. W. Lee's Son</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.H. Mattingly Frostburg, Md</u>		24a. REC'D BY REGISTRAR <u>13-28-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy X/Rae</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 7 1939

RECEIVED

12566

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d. STREET ADDRESS Winifred Road.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Raymond Middle Lee Last Mc Bride			4. DATE OF DEATH Month Dec. Day 2 Year 19 57		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22-1942		9. AGE (In years last birthday) 15 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Marvin M. McBride			14. MOTHER'S MAIDEN NAME Neoma Swick		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT (father) Marvin McBride, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 919.1 IMMEDIATE CAUSE (a) Maceration of brain (frontal lobe) DUE TO Fractured skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Gunshot wound					INTERVAL BETWEEN ONSET AND DEATH about 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deer hunting, one boy picked up his gun, accidentally went off and the ball hit the McBride boy in head.			
20c. TIME OF INJURY Month, Day, Year 9 Dec. 2 1957 Hour 9 o. m. PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm - near Corriganville, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H.V. Deming M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) H.V. Deming M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER Dec. 2-1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	
				22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.			24a. REC'D BY REGISTRAR Dec 4, 1957		
			24b. REGISTRAR'S SIGNATURE Donna Stuenkel		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
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79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
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BUREAU V. 3

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 10/15/57			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				d. STREET ADDRESS 246½ N. Centre St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theresa Middle B. Last McDonough				4. DATE OF DEATH Month December Day 25 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Leopold Berkenbaugh				14. MOTHER'S MAIDEN NAME Sarah Rowan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO Chronic nephritis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis				INTERVAL BETWEEN ONSET AND DEATH > > >			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15/57 , 19____, to 12/25/57 , 19____, that I last saw the deceased alive on 12/24/57 , 19____, and that death occurred on 5:10P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/26/57							
ACTUAL SIGNATURE James E. McLean M.D.				PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/57		22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cath. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24. REC'D BY REGISTRAR Dec. 28, 1957		24b. REGISTRAR'S SIGNATURE Tom van Stien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		Allegany	
DATE OF BIRTH		10/12/1877	
PLACE OF DEATH		Allegany County Infirmary	
DATE OF DEATH		10/12/1877	
SEX		Male	
RACE		White	
RELIGION		Roman Catholic	
MARRIAGE		Married	
NAME OF DECEASED		James J. McKeown	
NAME OF FATHER		James J. McKeown	
NAME OF MOTHER		Sarah McKeown	
NAME OF SPOUSE		Mary McKeown	
NAME OF CHILDREN		None	
NAME OF NEXT OF KIN		None	
NAME OF PHYSICIAN		None	
NAME OF BURIAL PLACE		None	
NAME OF FUNERAL HOME		None	
NAME OF CEMETERY		None	
NAME OF MINISTER		None	
NAME OF CHURCH		None	
NAME OF PARISH		None	
NAME OF DISTRICT		None	
NAME OF COUNTY		Allegany	
NAME OF STATE		Maryland	
NAME OF COUNTRY		United States	
NAME OF DECEASED		James J. McKeown	
NAME OF FATHER		James J. McKeown	
NAME OF MOTHER		Sarah McKeown	
NAME OF SPOUSE		Mary McKeown	
NAME OF CHILDREN		None	
NAME OF NEXT OF KIN		None	
NAME OF PHYSICIAN		None	
NAME OF BURIAL PLACE		None	
NAME OF FUNERAL HOME		None	
NAME OF CEMETERY		None	
NAME OF MINISTER		None	
NAME OF CHURCH		None	
NAME OF PARISH		None	
NAME OF DISTRICT		None	
NAME OF COUNTY		Allegany	
NAME OF STATE		Maryland	
NAME OF COUNTRY		United States	

RECEIVED
JAN 2 1933
BUREAU V. 3

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 608 Hill Top Drive				d. STREET ADDRESS 608 Hill Top Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CORA Middle NETTIE Last MC KENZIE				4. DATE OF DEATH Month December Day 25 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 6, 1877	
9. AGE (In years lost birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Slanesville, W.Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Wolford				14. MOTHER'S MAIDEN NAME Emile Wolford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Milton H. Meyers, 608 Hill Top Drive,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec. 25, 1957 , to Dec. 25, 1957 , that I last saw the deceased alive on Dec. 20, 1957 , and that death occurred at 8:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Clay E. Durrett, M.D. Cumberland, Md. 12/27/57							
ACTUAL SIGNATURE Clay E. Durrett, M.D.							
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				24a. REC'D BY REGISTRAR Dec. 28, 1957		24b. REGISTRAR'S SIGNATURE Low van Stuen, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUL 1967

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John Holland,

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BUREAU V. S.

JAN 2 1953

RECEIVED

John L. Haley, Cumberland

12569

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/12/57	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 1 Southern Hotel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eli Middle McKenzie Last McKenzie		4. DATE OF DEATH Month December Day 6 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/1883
9. AGE (In years lost birthday) yrs. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Orderly - Memorial Hospital Lonaconing, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joshua McKenzie		14. MOTHER'S MAIDEN NAME Mary Ellen Alexander	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-9881	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Chronic Myocarditis DUE TO Cerebral Arteriosclerosis DUE TO Hyperkalemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyperkalemia		INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/12/57 , 19____, to 12/6/57 , 19____, that I last saw the deceased alive on 12/6/57 , 19____, and that death occurred at 8:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/7/57			
ACTUAL SIGNATURE James E. McLean		M.D. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/9/1957	22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Dec 9, 1957		24b. REGISTRAR'S SIGNATURE John van Stuen, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. NAME OF DECEASED Allegany</p>		<p>2. PLACE OF BIRTH Allegany</p>	
<p>3. PLACE OF DEATH Allegany County Home</p>		<p>4. DATE OF DEATH 12/15/1917</p>	
<p>5. OCCUPATION Farmer</p>		<p>6. CAUSE OF DEATH Old age</p>	
<p>7. PLACE OF INTERMENT Allegany County Home</p>		<p>8. SIGNATURE OF DECEASED Allegany</p>	
<p>9. SIGNATURE OF WITNESSES Allegany</p>		<p>10. SIGNATURE OF PHYSICIAN Allegany</p>	
<p>11. SIGNATURE OF CLERK Allegany</p>		<p>12. SIGNATURE OF REGISTRAR Allegany</p>	

<p>13. NAME OF DECEASED Allegany</p>		<p>14. PLACE OF BIRTH Allegany</p>	
<p>15. PLACE OF DEATH Allegany County Home</p>		<p>16. DATE OF DEATH 12/15/1917</p>	
<p>17. OCCUPATION Farmer</p>		<p>18. CAUSE OF DEATH Old age</p>	
<p>19. PLACE OF INTERMENT Allegany County Home</p>		<p>20. SIGNATURE OF DECEASED Allegany</p>	
<p>21. SIGNATURE OF WITNESSES Allegany</p>		<p>22. SIGNATURE OF PHYSICIAN Allegany</p>	
<p>23. SIGNATURE OF CLERK Allegany</p>		<p>24. SIGNATURE OF REGISTRAR Allegany</p>	

RECEIVED
 DEC 11 1917
 BUREAU V. S.

RECEIVED

DEC 18 1957

BUREAU V. S.

HEALTH DEPT.

RECEIVED

Within 1 corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12571

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12582

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockwood</u> 75x-3 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>Rt. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Marlene</u> First <u>Joy</u> Middle <u>Miller</u> Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25-1957</u>
9. AGE (In years last birthday) <u>0</u> yrs. <u>3</u> Months <u>3</u> Days <u></u> Hours <u></u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Meyersdale, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ray A. Miller</u>	
14. MOTHER'S MAIDEN NAME <u>Helen Werner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(father) Ray A. Miller, Rockwood, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Streptococcus meningitis</u> about <u>14 hrs.</u> 340.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Dec. 11-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 13, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Garrett, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mills & Mickey Funeral Home, Rockwood, Penna.</u>		24a. REC'D BY REGISTRAR <u>Dec. 13/1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Jon van Stuen, M.D.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVVVVV

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
OFFICE OF THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten information.

BUREAU V. S.

DEC 16 1957

RECEIVED

12609

CERTIFICATE OF DEATH

12583

Reg. Dist. No. 6

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 338 Front		d. STREET ADDRESS 338 Front	
3. NAME OF DECEASED (Type or print) Winifred Bernadette Mills		4. DATE OF DEATH Dec. 12 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1872
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence Donahue		14. MOTHER'S MAIDEN NAME Bridgett McLarkie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT John Mills		Address Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 months 103 yrs -
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July - 1, 1957 , to Dec 12, 1957 , that I last saw the deceased alive on Dec 12, 1957 , and that death occurred at 10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE P. E. Berry		M.D. Piedmont W. Va	
PHYSICIAN'S NAME (Type) P. E. Berry		Piedmont W. Va	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 12/14/57	22c. NAME OF CEMETERY OR CREMATORY St. Peters	22d. LOCATION (City, town, or county) (State) Westernport, Md
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boral		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR DATE 12-14-57		24b. REGISTRAR'S SIGNATURE John C. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12572

CERTIFICATE OF DEATH

Reg. Dist. No.

12584

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02 years Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 429 Independence Street		d. STREET ADDRESS 429 Indpendence Street	
3. NAME OF DECEASED (Type or print) First Louis Middle Minnicks Last Minnicks		4. DATE OF DEATH Month December Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Columbia St. School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paulus Minnicks		14. MOTHER'S MAIDEN NAME Margaret Lauterback	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 429 Independence Street	
17. INFORMANT Mrs. John Phillips		Address Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma lower third esophagus 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Oct 57 , 19 57 , to 21 Dec , 19 57 , that I last saw the deceased alive on 20 Dec 57 , 19 57 , and that death occurred at 9:50 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/23/57			
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.			
PHYSICIAN'S NAME (Type) Alfred Van Ormer MD 122 South Center St. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 23, 1957	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Dec. 26, 1957 24b. REGISTRAR'S SIGNATURE Tom van Ormer, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12573 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		e. STREET ADDRESS <u>1314 Washington St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17-1884</u>
9. AGE (in years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>15</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouse caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Cumberland</u>	
11. BIRTHPLACE (foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Robbie Bittner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>W.W.I</u>	
17. INFORMANT <u>Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hema-pneumothorax</u> <u>900.0</u> DUE TO (b) <u>Punctured lung (left)</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>from fractured 5,6,& 7th.ribs post axillary region</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> <u>4 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>about</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps at home.</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-8</u> Hour <u>Dec. 19</u> 19 <u>57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 23-1957</u>	
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jon van Stuen, M.D.</u>	

MARYLAND DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE

RECEIVED
DEC 30 1957
BUREAU V. S.

Within corporate limits

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12586

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 12 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02. Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 623 Patterson Ave.		d. STREET ADDRESS 623 Patterson Ave.	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Neely		4. DATE OF DEATH Month Dec. Day 10 Year 19 57	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19-1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.	IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Gallitzen, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Austin Helsel		14. MOTHER'S MAIDEN NAME Mary Staum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (husband) James Neely, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertention DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden ? several years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 10-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 13, 1957	22c. NAME OF CEMETERY OR CREMATORY Alto Rest Cemetery	22d. LOCATION (City, town, or county) (State) Altoona, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE George Funeral Home, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Dec. 13/1957	
		24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.	

RECEIVED

DEC 13 1957

BUREAU V. 8

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

A/ARIZONA STATE DEPARTMENT OF HEALTH-BALTIMORE 10

12610 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY in 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 32 Beall St.			d. STREET ADDRESS 32 Beall St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELLA Middle (GUNNETT) Last NEFF			4. DATE OF DEATH Month DECEMBER Day 17 Year 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1863	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George Gunnett			14. MOTHER'S MAIDEN NAME Catherine Worsing		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Miss Virginia Neff, Frostburg, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH several years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 19 Dec 17 19 57 , that I last saw the deceased alive on Dec 17 19 57 , and that death occurred at 9:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED Dec 17 1957					
ACTUAL SIGNATURE W. O. McLane M.D.			DATE SIGNED Dec 17 1957		
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.			Frostburg, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-20-57	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,			24a. REC'D BY REGISTRAR DATE 12-20-57		
ADDRESS Frostburg, Md.			24b. REGISTRAR'S SIGNATURE Dr. Stanley H. Re		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 5 1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000		JAN 6 1968		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		DATE OF REGISTRATION		PLACE OF REGISTRATION	
...		

BUREAU V. 5

DEC 30 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12575 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12588

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ELTA Middle VEVA Last NIELD		4. DATE OF DEATH Month DECEMBER Day 21 Year 1957.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCTOBER 24, 1913
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME RUFUS DORSEY	
14. MOTHER'S MAIDEN NAME VEVA SHEETZ		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, Venous 492X DUE TO Toxic myocarditis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 1953, to 12/21 , 1957, that I last saw the deceased alive on 12/20 , 1957, and that death occurred at 1:45 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 128 Union Street DATE SIGNED	
ACTUAL SIGNATURE George M. Brown M.D.		PHYSICIAN'S NAME (Type) DR. GEORGE SIMONS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/1957	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		24. REC'D BY REGISTRAR Dec 23, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Lou van Stree, M.D.	

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DEC 26 1957

BUREAU V. S.

12576

CERTIFICATE OF DEATH

12589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 124 Virginia Avenue	
3. NAME OF DECEASED (Type or print) First Ora Middle Lee Last Nisewarner		4. DATE OF DEATH Month December Day 4 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1891
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Care Home	
11. BIRTHPLACE (State or foreign country) Virginia Brodway		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William A. Nisewarner		14. MOTHER'S MAIDEN NAME Emma Rinehart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 18 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 240x Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/10/55 , 19____, to 12/4/57 , 19____, that I last saw the deceased alive on 12/4/57 , 19____, and that death occurred at 6:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/5/57			
ACTUAL SIGNATURE James E. McLean		Dr. J. E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-7-57	22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery	22d. LOCATION (City, town, or county) (State) Terra Alta, W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarnelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE 7, 1957		24b. REGISTRAR'S SIGNATURE John van Stien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Maryland		DATE OF DEATH 12/11/1957	
PLACE OF DEATH Baltimore		AGE 35	
OCCUPATION Teacher		SEX Female	
RACE White		DATE OF BIRTH 10/1/1921	
MARRIAGE Married		PLACE OF BIRTH Virginia	
NAME OF DECEASED William A. Wiseman		DATE OF DEATH 12/11/1957	
PLACE OF DEATH Baltimore		AGE 35	
OCCUPATION Teacher		SEX Male	
RACE White		DATE OF BIRTH 10/1/1921	
MARRIAGE Married		PLACE OF BIRTH Virginia	
NAME OF DECEASED Maryland		DATE OF DEATH 12/11/1957	
PLACE OF DEATH Baltimore		AGE 35	
OCCUPATION Teacher		SEX Female	
RACE White		DATE OF BIRTH 10/1/1921	
MARRIAGE Married		PLACE OF BIRTH Virginia	

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DEC 11 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12577 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12590

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02. Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>1 403 Arch St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Genevieve</u> Last <u>Noonan</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11-1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>		11. BIRTHPLACE (State or foreign country) <u>Elko, Nevada</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Patrick M. King</u>				
14. MOTHER'S MAIDEN NAME <u>Maggie Mansfield</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Hospital records.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> about <u>1 month</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> <u>3 years or more</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>903.0 Fractured right femur at surgical neck.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>went to turn light on * * * * * in bathroom & fell to the floor, dizzy spell.</u>					
20c. TIME OF INJURY Hour <u>8</u> a. m. <u>Oct 27</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Cumberland</u>		(County) <u>Allegany</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 27-1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>I2-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cem.</u>			
22d. LOCATION (City, town, or county) <u>Mt. Savage, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli Cumberland, Md.</u>							
24a. REC'D BY REGISTRAR <u>Dec 28, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jon van Stien, M.D.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 2 1958

RECEIVED

12578

CERTIFICATE OF DEATH

12591

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN lb 24 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give place of death) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. STREET ADDRESS 810 Mac Donald Terrace	
3. NAME OF DECEASED (Type or print) First CHARLES Middle RICHARD Last NUZUM, JR.		4. DATE OF DEATH Month DECEMBER Day 25 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 16, 1945
9. AGE (In years last birthday) yrs. 12		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>School</i>	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES R. NUZUM SR		14. MOTHER'S MAIDEN NAME KATHRYN BUCHANAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles Nuzum, 810 Mac Donald Terr. Cumberland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchial Pneumonia 587.2 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Bronchiectasis, bilateral severe (c) Cribiform pneumonia (c) Congenital fibro-cystic disease Pancreas		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years 3 years some time	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 July , 19 57 , to 28 Dec , 19 57 , that I last saw the deceased alive on 25 Dec 57 , 19 57 , and that death occurred at 12:50 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. Alfred Van Ormer M.D. 122 SOUTH CENTRE STREET, CUMBERLAND, MD.			
ACTUAL SIGNATURE W. Alfred Van Ormer		PHYSICIAN'S NAME (Type) VAN ORMER, ALFRED W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 27, 1957	
24b. REGISTRAR'S SIGNATURE John Van Strien, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12579

CERTIFICATE OF DEATH

Reg. Dist. No.

12592

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Baltimore Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 9yrs, 8mo, 9da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat Furnace St.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle O'Rourke Last O'Rourke				4. DATE OF DEATH Month 12 Day 9 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1879		9. AGE (In years lost birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Naughton				14. MOTHER'S MAIDEN NAME Ann Dailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Frank E. Naughton		Address 112 N. Smallwood	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis							24 hrs.
DUE TO (b) Chronic Myocarditis							?
DUE TO (c) Coronary Arteriosclerosis							?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1st, 1952 to Dec. 9th, 1957 , that I last saw the deceased alive on Dec. 8th, 1957 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. McLean				ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 12/9/57	
PHYSICIAN'S NAME (Type) Dr. Mc Lean M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boal Funeral Home, Westernport, Maryland.				24a. REC'D BY REGISTRAR Dec. 10, 1957		24b. REGISTRAR'S SIGNATURE Don van Strien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3238

MAXIMUM STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. SIGNATURE OF DECEASED</p>		<p>10. SIGNATURE OF WITNESSES</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>	
<p>13. SIGNATURE OF JUDGE</p>		<p>14. SIGNATURE OF CLERK</p>	
<p>15. SIGNATURE OF NOTARY</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. SIGNATURE OF VENDOR</p>		<p>18. SIGNATURE OF DISTRIBUTOR</p>	
<p>19. SIGNATURE OF COLLECTOR</p>		<p>20. SIGNATURE OF TAXPAYER</p>	
<p>21. SIGNATURE OF SELLER</p>		<p>22. SIGNATURE OF BUYER</p>	
<p>23. SIGNATURE OF LESSOR</p>		<p>24. SIGNATURE OF LESSEE</p>	
<p>25. SIGNATURE OF MORTGAGOR</p>		<p>26. SIGNATURE OF MORTGAGEE</p>	
<p>27. SIGNATURE OF DONOR</p>		<p>28. SIGNATURE OF DONEE</p>	
<p>29. SIGNATURE OF TESTATOR</p>		<p>30. SIGNATURE OF LEGATEE</p>	
<p>31. SIGNATURE OF EXECUTOR</p>		<p>32. SIGNATURE OF ADMINISTRATOR</p>	
<p>33. SIGNATURE OF CREDITOR</p>		<p>34. SIGNATURE OF DEBTOR</p>	
<p>35. SIGNATURE OF GUARANTOR</p>		<p>36. SIGNATURE OF BENEFICIARY</p>	
<p>37. SIGNATURE OF SURETY</p>		<p>38. SIGNATURE OF OBLIGEE</p>	
<p>39. SIGNATURE OF OBLIGOR</p>		<p>40. SIGNATURE OF COUNTERPARTY</p>	
<p>41. SIGNATURE OF INTERESTED PARTY</p>		<p>42. SIGNATURE OF WITNESS</p>	
<p>43. SIGNATURE OF JURY</p>		<p>44. SIGNATURE OF COURT</p>	
<p>45. SIGNATURE OF JUDGE</p>		<p>46. SIGNATURE OF CLERK</p>	
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<p>421. SIGNATURE OF SURETY</p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

12580

CERTIFICATE OF DEATH

Reg. Dist. No.

12593

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gregory Middle Allen Last Pifer				4. DATE OF DEATH Month 12 Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/26/57	
9. AGE (In years last birthday) 10		IF UNDER 1 YEAR Months 10 Days 21		IF UNDER 24 HRS. Hours 21 Min. 10		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Jack Pifer				14. MOTHER'S MAIDEN NAME Hazel Van Meter Pifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Pt. chart Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.4 Agnucystosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aplastic Anemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X Pneumonia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-9 , 19 57 to 12-20 , 19 57 , that I last saw the deceased alive on 12-20 , 19 57 , and that death occurred at 11:40 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William P. James M.D.				DATE SIGNED 12-21-57			
PHYSICIAN'S NAME (Type) William P. James				Cumberland Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/1957		22c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		22d. LOCATION (City, town, or county) (State) Flintstone, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Dec. 22, 1957		24b. REGISTRAR'S SIGNATURE Tom van Strien, M.D.	

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BUREAU V. S.

DEC 26 1957

RECEIVED

1
 Within corporate limits
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12581
 CERTIFICATE OF DEATH

Reg. Dist. No. 12594

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 80yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 Cumberland, St.				d. STREET ADDRESS 123 Cumberland, St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Reid				4. DATE OF DEATH Month Dec. Day 13, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 9, 1877	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at Home				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME William Reid Baker				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Paul Reid Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 10, 1957 to Dec 13, 1957 , that I last saw the deceased alive on Dec 13, 1957 , and that death occurred at 9 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L B Mathews MD				ADDRESS (Street, city or town, state) 49 Green St Cumberland Md		DATE SIGNED 12-16-57	
PHYSICIAN'S NAME (Type) L B Mathews MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE Dec 16, 1957	
				24b. REGISTRAR'S SIGNATURE Jon van Steen M.D.			

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		12582		CERTIFICATE OF DEATH		12595	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		3. NAME OF DECEASED		4. DATE OF DEATH	
a. COUNTY	ALLEGANY	a. STATE	MARYLAND	(Type or print)	First Middle Last	Month	Day Year
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	CUMBERLAND	b. COUNTY	ALLEGANY		THELMA VIRGINIA RINEHART	DECEMBER	25 19 57
c. LENGTH OF STAY IN 1b	13 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	02 CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.	d. STREET ADDRESS	1 721 SHAWNEE AVE				
e. IS RESIDENCE ON A FARM?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
5. SEX	FEMALE	6. COLOR OR RACE	WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			AUGUST 13 1911	46	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	House wife	10b. KIND OF BUSINESS OR INDUSTRY	Ownhome	11. BIRTHPLACE (State or foreign country)	PRESTON CO. W.VA.	12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	JOSEPH B. COLE	14. MOTHER'S MAIDEN NAME	LILLIAN WOTRING				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	No	16. SOCIAL SECURITY NO.	None	17. INFORMANT	Darl Rinehart	Address	721 Shawnee Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage (massive) DUE TO (b) Hypertension DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1947, 19 to 25 Dec, 1957, that I last saw the deceased alive on 24 Dec, 1957, and that death occurred at 6:35 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE	Fuller B. Whitworth M.D. Cumberland Md					DATE SIGNED	26 Dec 57
PHYSICIAN'S NAME (Type)	Fuller B. Whitworth Cumberland, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)			
Burial	12-28-57	Carmel Cemetery	Aurora, WVa.				
23. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
James F. Scarpelli			Cumberland, Md.		Dec 28, 1957	Jon van Strien, M.D.	

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MEDICAL CERTIFICATION

12583

CERTIFICATE OF DEATH

12596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY 85x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ALBERT Middle TAYLOR Last RINKER				4. DATE OF DEATH Month DECEMBER Day 18 Year 19 57.			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 12, 1885	
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Telephone Co		11. BIRTHPLACE (State or foreign country) PURGITTSTVILLE, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME SYLVESTER RINKER				14. MOTHER'S MAIDEN NAME EMMA HIGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 232-09-0571		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardio (c) Vascular disease INTERVAL BETWEEN ONSET AND DEATH One week Long time							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-14, 1957 to 12-18, 1957 , that I last saw the deceased alive on 12-18, 1957 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. J. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland MD DATE SIGNED 12/19/57			
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 21/57		22c. NAME OF CEMETERY OR CREMATORY Bever Run Cemetery		22d. LOCATION (City, town, or county) (State) Burlington W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Meryl Combs				ADDRESS Romney, W. Va.		24a. REC'D BY REGISTRAR Dec. 20, 1957	
				24b. REGISTRAR'S SIGNATURE Townsend Shien, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

STATE OF MARYLAND COUNTY OF ALLEGANY		MARITAL STATUS SINGLE	
DECEASED J. DAVIS		PLACE OF DEATH HOSPITAL	
DATE OF DEATH 1957		PLACE OF BIRTH WEST VIRGINIA	
SEX MALE		RACE WHITE	
AGE 45		OCCUPATION FARMER	
NAME OF DECEASED J. DAVIS		NAME OF NEXT OF KIN J. DAVIS	
ADDRESS 123 MAIN ST.		CITY HARRISBURG	
COUNTY ALLEGANY		STATE PENNSYLVANIA	
DATE OF DEATH 1957		PLACE OF DEATH HOSPITAL	
NAME OF DECEASED J. DAVIS		NAME OF NEXT OF KIN J. DAVIS	
ADDRESS 123 MAIN ST.		CITY HARRISBURG	
COUNTY ALLEGANY		STATE PENNSYLVANIA	

RECEIVED
 DEC 23 1957
 BUREAU V. S.

12584

CERTIFICATE OF DEATH

12597

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 1yr. 8m. 13da.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Virginia Izora Ryan			4. DATE OF DEATH Dec. 2 19 57		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1870		9. AGE (In years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Parsons, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Corrick			14. MOTHER'S MAIDEN NAME Elousa Turner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Ray. T. Ryan Address Rt. 6, Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis (c) Cerebral Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 16 hrs. ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 53 to Dec. 2nd 19 57 , that I last saw the deceased alive on Dec. 2nd 19 57 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 12/3/57	
PHYSICIAN'S NAME (Type) James E. McLean					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/5/1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight		ADDRESS Cumberland, Md.		24. REC'D BY REGISTRAR Dec. 5, 1957	24b. REGISTRAR'S SIGNATURE Jon van Stuen, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998

DEC 9 1957

RECEIVED

12619 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allegany				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Borden Mines, R. D. No 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. #2, Frostburg, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Schr Last iver				4. DATE OF DEATH Month 12 Day 3 Year 1957			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH II-3-1873	
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84		IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min. 84			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathaniel Dunn				14. MOTHER'S MAIDEN NAME Jeannette Neilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Frank Schriver, R. D. #2, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 450.0 DUE TO arterio sclerosis (c) 450.0 DUE TO arterio sclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 27, 1957 , to Dec 3, 1957 , that I last saw the deceased alive on Nov 27, 1957 , and that death occurred at 3:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wom Lane M.D.				ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED Dec 4, 1957			
PHYSICIAN'S NAME (Type) Wom Lane M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-1957		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Haier Funeral Home ADDRESS 25 E. Main				24a. REC'D BY REGISTRAR DATE 12-5-57		24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Page Two

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>10. SIGNATURE OF WITNESS [REDACTED]</p>		<p>11. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>12. SIGNATURE OF CORONER [REDACTED]</p>	
<p>13. SIGNATURE OF JUDGE [REDACTED]</p>		<p>14. SIGNATURE OF CLERK [REDACTED]</p>		<p>15. SIGNATURE OF [REDACTED] [REDACTED]</p>	

BUREAU V. S.

DEC 12 1957

RECEIVED

1 FOR STATE HEALTH DEPT M 99 D.O.A. at the Memorial Hospital I 0 2 VS. A15ME SM 2/57 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12585 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12599

Reg. Dist. No.

Within corporate limits

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

16 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

x2 Cumberland, Bowmans Addition

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

at the Memorial Hospital

d. STREET ADDRESS

1 R.F.D. #3

e. IS RESIDENCE ON A FARM

YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

William

First

Thornton

Middle

Sheally

Last

4. DATE OF DEATH

Dec.

12

1957

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Dec. 19-1898

9. AGE (In years last birthday)

58 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Asst. car foreman- W. Md. R. Ry.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ufalla, Alabama

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jonh B. Sheally

14. MOTHER'S MAIDEN NAME

Lelia Beckham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

yes about 1 month.

16. SOCIAL SECURITY NO.

17. INFORMANT

(wife) Beatrice Sheally, Cumberland, Md.

Address R.F.D./#3

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Coronary sclerosis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour o. m.
p. m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

H. V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

H. V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒ Dec. 13-1957

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Dec. 15, 1957

22c. NAME OF CEMETERY OR CREMATORY

Rose Hill Cemetery

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer,

ADDRESS

Cumberland, Md.

24a. REC'D BY REGISTRAR

DATE Dec. 16, 1957

24b. REGISTRAR'S SIGNATURE

Jon van Strien, M.D.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1957

RECEIVED

John E. Butler, Campbell, Md.
Dec. 15, 1957, Rose Hill Cemetery
Campbell, Md.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The **1** copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12600

12620 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>W. Va.</u>		COUNTY <u>Mineral</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>McCoole</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Keyser</u>		✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>368 Queen Street</u>				STREET ADDRESS <u>159½ West Piedmont Street</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Edith</u> (First) <u>Myrtle</u> (Middle) <u>Shears</u> (Last)				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>11</u> (Year) <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 31, 1898</u>	
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Romney West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Timbrook</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Fout</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-6875</u>		17. INFORMANT & ADDRESS <u>Mrs. Pearl Hartman, Keyser W. Va.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1443X IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Unattended</u> to <u>24 hours</u> that I last saw the deceased alive on <u>prior to death</u> and that death occurred at <u>19</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Paul Healy</u>				ADDRESS (Street, city, town, state) <u>Keyser W. Va.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/14/57</u>		NAME OF CEMETERY OR CREMATORY <u>Queens Point</u>		LOCATION (City, town, or county) (State) <u>Keyser W. Va.</u>	
24. REC'D BY REGISTRAR DATE <u>DEC 17 '57</u>		REGISTRAR'S SIGNATURE <u>DeLoach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rogers Funeral Home Inc, Keyser W. Va.</u>		ADDRESS	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

Reg. Gen. No.

1. DATE OF DEATH

2. TIME OF DEATH

3. PLACE OF DEATH

4. NAME OF DECEASED

5. SEX

6. AGE

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF VILLAGE CLERK

22. SIGNATURE OF CITY CLERK

23. SIGNATURE OF STATE CLERK

24. SIGNATURE OF NATIONAL CLERK

25. SIGNATURE OF INTERNATIONAL CLERK

26. SIGNATURE OF UNITED STATES CLERK

27. SIGNATURE OF FOREIGN CLERK

28. SIGNATURE OF OTHER CLERK

29. SIGNATURE OF DECEASED

30. SIGNATURE OF SURVIVORS

31. SIGNATURE OF ESTATE

32. SIGNATURE OF LEGAL REPRESENTATIVE

33. SIGNATURE OF NEXT OF KIN

34. SIGNATURE OF OTHER RELATIVE

35. SIGNATURE OF FRIEND

36. SIGNATURE OF OTHER PERSON

37. SIGNATURE OF OTHER PARTY

38. SIGNATURE OF OTHER INTERESTED PARTY

39. SIGNATURE OF OTHER PERSON

40. SIGNATURE OF OTHER PARTY

41. SIGNATURE OF OTHER PERSON

42. SIGNATURE OF OTHER PARTY

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99. SIGNATURE OF OTHER PERSON

100. SIGNATURE OF OTHER PARTY

BUREAU V. S.

DEC 17 1957

RECEIVED

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12621 CERTIFICATE OF DEATH

12601
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Charlestown Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle E. Last Shockey				4. DATE OF DEATH Month December Day 27 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1876		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Shockey				14. MOTHER'S MAIDEN NAME Elizabeth Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT John Shockey Jr		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 year Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 56 , to Dec. 27 , 19 57 , that I last saw the deceased alive on Dec 27 , 19 57 , and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leslie R. Miles Jr. M.D. 12-28-57							
ACTUAL SIGNATURE Leslie R. Miles Jr.				PHYSICIAN'S NAME (Type) LESLIE R. MILES JR. LONACONING MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/29/57		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 12/30/57	
				24b. REGISTRAR'S SIGNATURE Junette M. Boal			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DECEASED'S NAME John Joseph Shockey		PLACE OF BIRTH Baltimore, Md.	
SEX Male		DATE OF BIRTH May 12, 1890	
OCCUPATION Laborer		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		PLACE OF INTERMENT St. Mary's Cemetery, Baltimore, Md.	
DATE OF DEATH May 12, 1935		TIME OF DEATH 10:30 A.M.	
SIGNATURE OF DECEASED John Joseph Shockey		SIGNATURE OF WITNESS George Nicholas	
SIGNATURE OF PHYSICIAN George Nicholas		SIGNATURE OF CLERK George Nicholas	

BUREAU V. 2

JAN 9 1935

RECEIVED

12611

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
c. LENGTH OF STAY IN 1b life		d. STREET ADDRESS 91 Broadway	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 91 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J Middle LOUIS Last SLUSS		4. DATE OF DEATH Month Dec. Day 30 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY State road	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Sluss		14. MOTHER'S MAIDEN NAME Anna Alexander	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 2I4-05-9690	
17. INFORMANT Mrs. Margaret Sluss, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 4 , 19 57 , to Dec 30 , 19 57 , that I last saw the deceased alive on Dec 13 , 19 57 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED Dec 31 1957			
ACTUAL SIGNATURE W. O. McLane		PHYSICIAN'S NAME (Type) W. O. McLane, M. D. Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-2-58	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR Jan 3 1958		24b. REGISTRAR'S SIGNATURE Nancy Ray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 3 1958
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 224 1-8-58 et

CERTIFICATE OF DEATH

12622

12603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Alegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 3, Valley Road, Cumberland 22yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 3, Valley Road, Cumberland, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) Rt. 3, Valley Road, Cumberland, Maryland				e. STREET ADDRESS Rt. 3, Valley Road, Cumberland			
3. NAME OF DECEASED (Type or print) Wilbur Wadsworth Smith				4. DATE OF DEATH Month December Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893 January 17, 1893		9. AGE (In years last birthday) 64 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Great Cacapon, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW1		16. SOCIAL SECURITY NO. 705-09-4875		17. INFORMANT Mrs. Thelma H. Smith Rt. 3, Valley Road Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-renal vascular disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days 4 years						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Sept _____, 19 57 , to Dec 28 _____, 19 57 , that I last saw the deceased alive on Dec 28 _____, 19 57 , and that death occurred at 1 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lysle R. Everhart M.D.				ADDRESS (Street, city or town, state) 525 Hall Hwy La Vale, Maryland DATE SIGNED 12/29/57			
PHYSICIAN'S NAME (Type) Lysle Everhart M.D.				La Vale, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE Dec 31, 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1960

[illegible]

BUREAU V. B.

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12604

12586

CERTIFICATE OF DEATH

Item 1, Film G224, 1/21/58 rky

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>PENNA</u>		COUNTY <u>SOMERSET</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>5 WEEKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WELLERSBURG 75x-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>535 N. Mechanic ST</u>		(Daughter's Home)		STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>LILLIE MAE STURTZ</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 7, 1957</u>			
5. SEX <u>FEMALE WHITE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JUNE 27, 1872</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>CORRIGANVILLE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL GEARY</u>				14. MOTHER'S MAIDEN NAME <u>LUCINDA HINER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs. Florence Drayer, Cumberland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.2 IMMEDIATE CAUSE (A) <u>Chronic Myocardiosis</u>						<u>5 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 7, 1957</u> , to <u>Dec 7, 1957</u> , that I last saw the deceased alive on <u>Dec 7, 1957</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John A. Lopper</u>				ADDRESS (Street, city, town, state) <u>Hyndman Pa</u>		DATE SIGNED <u>12.9.57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec. 10, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Cooks Cemetery</u>		LOCATION (City, town, or county) <u>Wellersburg, Pa</u>	
24. REC'D BY REGISTRAR <u>Dec 10, 1957</u>		REGISTRAR'S SIGNATURE <u>John A. Lopper, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey N. Ziegler</u>		ADDRESS <u>Hyndman, Pa.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A153 1-55 10M

13530 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Form 100-100

1. Name of deceased (Print or write full name)

2. Sex

3. Date of birth

4. Place of birth

5. Date of death

6. Time of death

7. Cause of death (Print or write full name)

8. Place of death

9. Date of burial

10. Time of burial

11. Name of funeral home

12. Name of physician

13. Name of coroner

14. Name of registrar

15. Name of undertaker

16. Name of cemetery

17. Name of church

18. Name of minister

19. Name of sexton

20. Name of sexton

21. Name of sexton

22. Name of sexton

23. Name of sexton

24. Name of sexton

25. Name of sexton

26. Name of sexton

27. Name of sexton

28. Name of sexton

29. Name of sexton

30. Name of sexton

31. Name of sexton

32. Name of sexton

33. Name of sexton

34. Name of sexton

35. Name of sexton

36. Name of sexton

37. Name of sexton

38. Name of sexton

39. Name of sexton

40. Name of sexton

41. Name of sexton

42. Name of sexton

43. Name of sexton

44. Name of sexton

45. Name of sexton

BUREAU V. S.

RECEIVED
DEC 18 1957

EXHIBITION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12605
12587 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 4
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>16 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					/ d. STREET ADDRESS <u>615 Elwwood St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Lee</u> Last <u>Swartley</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>19 57</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 22-1902</u>		9. AGE (In years last birthday) <u>55</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress-Johnson Heights Cafeteria</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Md.</u>			11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		
13. FATHER'S NAME <u>Clark D. Rinker</u>					14. MOTHER'S MAIDEN NAME <u>Fannie Spates</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-20-5741</u>		17. INFORMANT Address <u>(husband) Edgar L. Swartley, Cumberland, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>about 3 months.</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 12-1957</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Pk. Cumberland, Md.</u>			22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>Dec. 16, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John van Stuen M.D.</u>			

BUREAU V. S.

DEC 18 1957

RECEIVED

12588 CERTIFICATE OF DEATH

12606

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS Latrobe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sophia Middle Tribut Last Tribut				4. DATE OF DEATH Month 12/21/57 Day 19 Year 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 8 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME August Tribut				14. MOTHER'S MAIDEN NAME Christine Langhutz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Pt's Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcomatosis Carcinomatosa 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Fibrosarcoma uteri DUE TO (c) adenocarcinoma uteri INTERVAL BETWEEN ONSET AND DEATH 8 mo + yr. 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-10-57 , 19 57 , to 12-21-57 , 19 57 , that I last saw the deceased alive on 12-20-57 , 19 57 , and that death occurred at 3:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 12-21-57 ACTUAL SIGNATURE C. Zimmermann M.D. C. Zimmermann PHYSICIAN'S NAME (Type) C. Zimmermann M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec. 23, 1957		Rose Hill Cem.		Cumb. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lawson Stein Inc.				ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR Dec. 23, 1957	
				24b. REGISTRAR'S SIGNATURE Jon van Steen, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 26 1957

RECEIVED

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12607

Reg. Dist. No.

12589

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>306 N.Mechanic St.</u>			d. STREET ADDRESS <u>306 N.Mechanic St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>John</u> Last <u>Troshak</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>19 57</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16-1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Franz Dvorah</u>			
14. MOTHER'S MAIDEN NAME <u>Marianna Lipa</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>217-14-46291</u>		17. INFORMANT Address <u>(Daughter) Mrs. Mary Reall, Brookside, Ohio</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (c) <u>Coronary sclerosis</u> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H.V.Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Dec. 24-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bayard Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Bayard, West Virginia</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>Dec. 26, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Jon van Strien, M.D.</u>					

RECEIVED
DEC 30 1957
BUREAU V. 1

RECEIVED
DEC 30 1957
BUREAU V. 1

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF DEATH	
5. PLACE OF DEATH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. MANNER OF DEATH	
9. SIGNATURE OF EXAMINER	
10. SIGNATURE OF WITNESS	
11. SIGNATURE OF CORONER	
12. SIGNATURE OF JURY	
13. SIGNATURE OF DISTRICT ATTORNEY	
14. SIGNATURE OF CLERK	
15. SIGNATURE OF SHERIFF	
16. SIGNATURE OF JUDGE	
17. SIGNATURE OF PROSECUTOR	
18. SIGNATURE OF DEFENSE COUNSEL	
19. SIGNATURE OF JURY	
20. SIGNATURE OF COURT	

12612

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle TAYLOR Last WALKER				4. DATE OF DEATH Month Dec. Day 4, Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1900	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.		IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William B. Walker				14. MOTHER'S MAIDEN NAME Emily Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-09-6590			
17. INFORMANT Mrs. Samuel Walker, Frostburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of trachea 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of esophagus DUE TO (c) 6 months INTERVAL BETWEEN ONSET AND DEATH 3 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 1957, to Dec. 4 , 1957, that I last saw the deceased alive on Dec. 4 , 1957, and that death occurred at 7:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED 12/6/57							
ACTUAL SIGNATURE W. E. Gattens M.D.							
PHYSICIAN'S NAME (Type) W. E. Gattens, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 -7-1957		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-7-57	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

RECEIVED
DEC 12 1957
BUREAU V. S.

12590

CERTIFICATE OF DEATH

12609

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walsh, John Harvey		4. DATE OF DEATH 12 - 21 - 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1901
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) furloughed machinist's helper - Chinese Corp. Md.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME James Walsh		14. MOTHER'S MAIDEN NAME Cora May Walsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-3355	
17. INFORMANT Patients chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/1 , 19 57 , to 12/21 , 19 57 , that I last saw the deceased alive on 12/21 , 19 57 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley, Jr.		ADDRESS (Street, city or town, state) 406 N. Centre St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. Leo Ley M.D.		DATE SIGNED 12/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 24, 1957	22c. NAME OF CEMETERY OR CREMATORY Saint Patrick's Cemetery	22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		24a. REC'D BY REGISTRAR Dec. 23, 1957	
ADDRESS Frostburg, Md.		24b. REGISTRAR'S SIGNATURE John Van Streen, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		39		JAN 5 1918	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN.		ATTORNEY		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968	

BUREAU V. 1

DEC 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12613

CERTIFICATE OF DEATH

Reg. Dist. No.

12610

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Leonard</u> Last <u>White</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 18, 1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY IN BIRTHPLACE (State or foreign country) <u>B & O Railroad</u>	
13. FATHER'S NAME <u>Edward White</u>		14. MOTHER'S MAIDEN NAME <u>Blaise Frazier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-16-4145</u>	
17. INFORMANT Address <u>Mary Ann White - Frostburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>4 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Dec 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 5th</u> , 19 <u>57</u> , and that death occurred at <u>4:57</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Davis</u> M.D.		ADDRESS (Street, city or town, state) <u>2 Broadway Frostburg Md</u>	
PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>		DATE SIGNED <u>12/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec 9, 1957</u>	<u>Frostburg Memorial Park</u>	<u>Frostburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>John J. Hafler</u> <u>Cumberland Md.</u>		DATE <u>12-9-57</u>	<u>Miss Nancy N. Day</u>

DEC 12 1957

RECEIVED

Within Corporate Limits

Item 9 Film 221 1-6-58 et

DR. W.F. WMS.

12591

CERTIFICATE OF DEATH

Reg. Dist. No.

12611

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SUSIE Jane WILLISON		4. DATE OF DEATH Month Day Year DECEMBER 23 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/11 1891
9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Fort Ashby, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GIBSON PYLES		14. MOTHER'S MAIDEN NAME MOLLIE BERRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-6430	
17. INFORMANT Mrs. Laurance Alkire		Address Fort Ashby W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19-57 , to 12-23-57 , that I last saw the deceased alive on 12-22-57 , 19 57 , and that death occurred at 12:30A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. J. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 12/23/57	
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57	
22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		22d. LOCATION (City, town, or county) (State) Fort Ashby, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Dec. 26, 1957		24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 1963

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15
 WITH STATE LIMITED
 HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12612

Reg. Dist. No.

12592

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 3 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 629 Henderson Blvd.		d. STREET ADDRESS 629 Henderson Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) Henry Stewart Winebrenner		4. DATE OF DEATH Month Dec. Day 15 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17-1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender- Cumberland Brewing Co.		10b. KIND OF BUSINESS OR INDUSTRY Mt. Savage, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME Stewart Winebrenner		14. MOTHER'S MAIDEN NAME Mary Sophia Winebrenner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes.		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) W.W.1	
17. INFORMANT (wife) Helen Twigg Winebrenner, Cumberland		Address Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion & Malnutrition 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of cecum & colon with metastasis DUE TO (c) to abdominal organs.		INTERVAL BETWEEN ONSET AND DEATH gradual 4-5 months.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE H.V. Deming M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) H.V. Deming M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	Dec. 15-1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/18/57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR Dec 18, 1957		24b. REGISTRAR'S SIGNATURE Jon van Stuen, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 20 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12613
9

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Centennial Ave. Ext.</u>		d. STREET ADDRESS <u>Centennial Ave. Ext.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank R. Winner</u>		4. DATE OF DEATH Month Day Year <u>Dec. 31 19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Salvage Dept. Celanese Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frostburg, Md.</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Harmon Winner</u>		14. MOTHER'S MAIDEN NAME <u>Laura Crowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-2723</u>	
17. INFORMANT <u>(son) Raymond Winner, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease. About 4 yrs.</u> (c) <u>stating the underlying cause lost.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Dec. 31-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 3 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Nancy Rice</u>			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
198-1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 3 1938
BUREAU V. A.

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature. The form is oriented horizontally but contains vertical text on the left side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12593

CERTIFICATE OF DEATH

12614

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.				c. LENGTH OF STAY IN 1b 3 days 7 hrs 02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Carl Last Wisegarver, Sr				4. DATE OF DEATH Month 12 Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/82	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired W.M.R.R. Train Dispatcher				10b. KIND OF BUSINESS OR INDUSTRY Penna.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Wisegarver				14. MOTHER'S MAIDEN NAME Elizabeth Drollinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 705-10-6046		17. INFORMANT Patients chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA (2 days) 48 hrs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL INFARCTION - RIGHT 5 days DUE TO (c) CEREBRAL HEMORRHAGE - RIGHT 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X ARTERIOSCLEROSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 12/4 , 19 57 , to 12/8 , 19 57 , that I last saw the deceased alive on 12/7/57 , 19 57 , and that death occurred at 9:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 GREENE ST DATE SIGNED 12/8/57 ACTUAL SIGNATURE S G WEISMAN M.D. PHYSICIAN'S NAME (Type) S G WEISMAN MD CUMBERLAND, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/57		22c. NAME OF CEMETERY OR CREMATORY Everett Cemetery		22d. LOCATION (City, town, or county) (State) Everett, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				23a. REC'D BY REGISTRAR Dec. 9, 1957		23b. REGISTRAR'S SIGNATURE John Van Arman, M.D.	

BUREAU V. S.

DEC 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12594

CERTIFICATE OF DEATH

12615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 33 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. STREET ADDRESS 6 ALTAMONT TERRACE			
3. NAME OF DECEASED (Type or print) First RUSSELL Middle Howard Last WITHERS				4. DATE OF DEATH Month DECEMBER Day 19 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JUNE 6, 1909	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
13. FATHER'S NAME WILLIAM WITHERS (DECEASED)				14. MOTHER'S MAIDEN NAME MARTHA SWADLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-05-4588		17. INFORMANT PT'S CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis with Decompensation 1 month DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 11-15-57 to 11-19-57 that I last saw the deceased alive on 11-18-57 , and that death occurred at 5:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 12-20-57 ACTUAL SIGNATURE J. F. Johnson Jr. M.D. PHYSICIAN'S NAME (Type) James T. Johnson Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE OF RECOF 12-21-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24. REC'D BY REGISTRAR Dec. 21, 1957	
24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 26 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12595

Item 9 Film G223 12-26-57 et

Reg. 126164

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Md.

b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural- Old Town x2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. Memorial Hospital

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)First Middle Last
Charles Franklin Witt4. DATE
OF
DEATHMonth Day Year
Dec. 10 19 57

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Jan. 18-1889

9. AGE (In years
last birthday)

68 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired coal miner & Trackman -B&O.R.Ry.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Edward Witt

14. MOTHER'S MAIDEN NAME

Alecindia Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, never or unknown) (If yes, give war or dates of service)

Yes

W.W.I

16. SOCIAL SECURITY NO.

220-10-1799

17. INFORMANT

(nephew) Charles Witt

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

420.1 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Coronary sclerosis

?

DUE TO (c) Arteriosclerosis

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.
p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

H.V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒ Dec. 11-195722a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Dec. 13, 1957

22c. NAME OF CEMETERY OR CREMATORY

Rose Hill Cemetery

22d. LOCATION (City, town, or county)

Cumberland, Maryland.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

William H. Kight, Cumberland, Maryland.

24a. REC'D BY REGISTRAR

Dec. 12, 1957

24b. REGISTRAR'S SIGNATURE

Jon van Strien, M.D.

STATE
DEPT.

1951

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12617	
Within corporate limits 12596										CERTIFICATE OF DEATH	
Reg. Dist. No. 4											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>85 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 Boone St.</u>					d. STREET ADDRESS <u>34 Boone St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>E.</u> Last <u>Yost</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>19 57</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 10, 1868</u>		9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Orleans, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Clay</u>					14. MOTHER'S MAIDEN NAME <u>Mary Ann Fitzpatrick</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Mrs. Emil Krampf, Cumberland, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>30 hr</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 12, 19 57</u> to <u>Dec 13, 19 57</u> that I last saw the deceased alive on <u>Dec 13, 19 57</u> , and that death occurred at _____ M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Clay E. Durrett</u>				ADDRESS (Street, city or town, state) <u>236 W. Virginia Ave., Cumberland, Md.</u>				DATE SIGNED <u>12/14/57</u>			
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett</u>				236 Virginia Ave., Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>				22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>						ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 16, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Don van Strien, M.D.</u>	

